PSYCHOSOMATICS

OFFICIAL PUBLICATION
OF THE
ACADEMY
OF
PSYCHOSOMATIC
MEDICINE

A
JOURNAL
EXPLORING
THE ROLE OF
PSYCHIATRY
IN THE
DAILY
PRACTICE
OF
TOTAL
MEDICINE

If you are not already a member of the Academy of Psychosomatic Medicine or do not now subscribe to Psychosomatics you will want to look at pg. 367.

PSYCHOSOMATICS

Official Journal of The Academy of Psychosomatic Medicine

Published by

THE ACADEMY OF PSYCHOSOMATIC MEDICINE

PHYSICIANS POSTGRADUATE PRESS
277 Broadway - New York 7, New York

Editorial

The current issue of *Psychosomatics* may mark the end of the first year of publication, but to the Editor it still seems to be only the beginning. Our stated goal has been to "explore the role of psychiatry in the daily practice of total medicine" —and it must be readily admitted that this is still in the exploratory stages. Perhaps it is better that it remain that way, since exploration has always been much more exciting than actual discovery.

At any rate, it should be no surprise to our faithful readers to learn that we have been equally concerned with the need to explore the role of medicine in the daily practice of psychiatry. If this doesn't appear on the frontispiece, perhaps it isn't solely due to the obvious fact that it would crowd the page considerably. It may be related to the deeper realization that this additional challenge may be too large a bolus to digest for a young journal that much like an infant, is not ready as yet for solid food.

It is with this thought in mind that we plan ahead for 1961—with the hope that increasing maturity will permit us to reach a fuller fruition of our potentialities. It is our belief that one method of increasing the value of the Journal would be to increase the Editorial Board so that a more adequate coverage of the pertinent literature in the field of psychosomatic correlations can be accomplished. The present Editorial Board (with a long list of Chiefs, but no Indians), has been considerably cut so that each Associate Editor would be more closely associated with the responsibilities involved in putting out the Journal. Many Contributing Editors will be added; they have been selected, not only because of their basic qualifications to cover their respective areas of interest, but because of their proven motivation to accept the responsibilities that go with their assignments.

Increasing the published abstracts and book reviews, in which many areas of medical and psychiatric theory and practice are covered, will give *Psychosomatics* greater value to its readers. Yet, if these abstracts are divided into distinct sections, each with its own specialty heading, the very purpose of the Journal will be defeated. It is our hope that if these areas merge and coalesce, rather than diverge and digress, a greater service will be accomplished. An occasional reader may perhaps be lured into perusing something which lies outside of his special field of interest. If this is "brain-washing," at least our plans are out in the open.

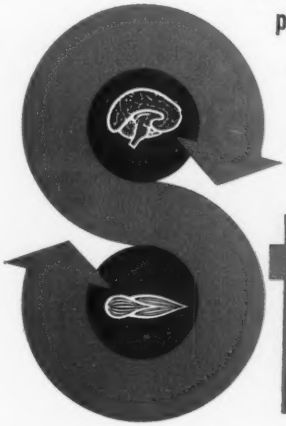
Our Advisory Editorial Board has also had additions, not only in names but in their obligations. It is the Editor's hope that in this way his own blind spots can be picked up before they become irreversible field defects.

Finally, it must be pointed up that our readers, too, have obligations—for only through their comments, critique, and "Letters to the Editor," can the Journal eventually better meet their needs. It should be noted, and for this I am indebted to the psychoanalysts, that silence is a form of "resistance" and is usually interpreted as "hostility." If this is not the case, it would be interesting to obtain your reactions to this opinion. If enough letters are received, and if they prove sufficiently provocative, perhaps they can be published. There would be no "controls," and no "double blinds," but I'm certain it will prove to be stimulating.

W.D.

a new, improved, more potent relaxant for anxiety and tension

- effective in half the dosage required with meprobamate
- much less drowsiness than with meprobamate, phenothiazines, or the psychosedatives
- does not impair intellect, skilled performance, or normal behavior
- neither depression nor significant toxicity has been reported



alert tranquillity

Striatran®

EMYLCAMATE®

- a familiar spectrum of antianxiety and muscle-relaxant activity
- no new or unusual effects—such as ataxia or excessive weight gain
- may be used in full therapeutic dosage even in geriatric or debilitated patients
- no cumulative effect
- simple, uncomplicated dosage, providing a wide margin of safety for office use

STRIATRAN is indicated in anxiety and tension, occurring alone or in association with a variety of clinical conditions.

Adult Dosage: One tablet three times daily, preferably just before meals. In insomnia due to emotional tension, an additional tablet at bedtime usually affords sufficient relaxation to permit natural sleep.

Supply: 200 mg. tablets, coated pink, bottles of 100.

While no absolute contraindications have been found for Striatran in full recommended dosage, the usual precautions and observations for new drugs are advised.

For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., WEST POINT, PA.

STRIATRAN IS A TRADEMARK OF MERCK & CO., INC.

PSYCHOSOMATICS

VOLUME I - NUMBER 6 NOVEMBER - DECEMBER 1960

Contents

INFORMATION FOR CONTRIBUTORS

While *Psychosomatics* is the official journal of the Academy of Psychosomatic Medicine, its pages are open to all authors interested in the concept of total medicine. Original papers, book reviews, abstracts, letters: all will be considered by the editors for publication. Criteria for publication are scientific merit, interest, timeliness, and pertinence to the role of psychiatry in the daily practice of medicine.

Manuscripts

The *original* manuscripts of papers read at the annual meetings of the Academy should be left in the Press Room during the meetings, or sent to the Editor promptly afterward. Do not deposit carbon copies.

Papers read at the annual meetings become the property of the Academy. Not all papers read, however, can be published, and authors wishing to publish in other vehicles will first secure from the Editor the release of their manuscripts.

Papers will not be accepted for publication if they have been already published.

Papers contributed during the year (not on the annual program) should be sent to the Editor.

Style

Manuscripts should be typewritten, double spaced, on one side of the paper. They must be prepared in conformity with the general style of *Psychosomatics*. Retain a carbon copy of manuscript and duplicates of tables, figures, etc., for use should the originals be lost in the mails.

Illustrations

Authors will be asked to meet printer's costs of reproducing excessive illustrative material. Copy for illustrations cannot be accepted unless properly prepared for reproductions. Wherever possible, drawings and charts should be made with India ink for photographic reproduction as zinc etchings. Photographs for halftone reproduction should be glossy prints. Illustrations should be as small as possible without sacrificing important detail.

Authors' Corrections in Proofs

Corrections, additions or deletions made by authors are to be charged to them. Proper editing of original manuscript is important to avoid the expense of correction.

Tables

Tables should be typed on separate sheets. Tables are much more expensive to set than text material and should be used only where necessary to clarify important points. Authors will be asked to defray cost of excessive tabular material.

References

References should be assembled according to author in a terminal bibliography, referred to in text by numbers in parentheses. Bibliographical material should be typed in accordance with the following style for journals and books respectively:

1. Rosen, H.: *Am. J. Psychiat.*, 107:917, June 1957.
2. Gesell, A., and Ilg, F. L.: *The Child from Five to Ten.* New York: Harper & Bros., 1946.

Abbreviations should conform to the style used in the Quarterly Cumulative Index Medicus.

* * *

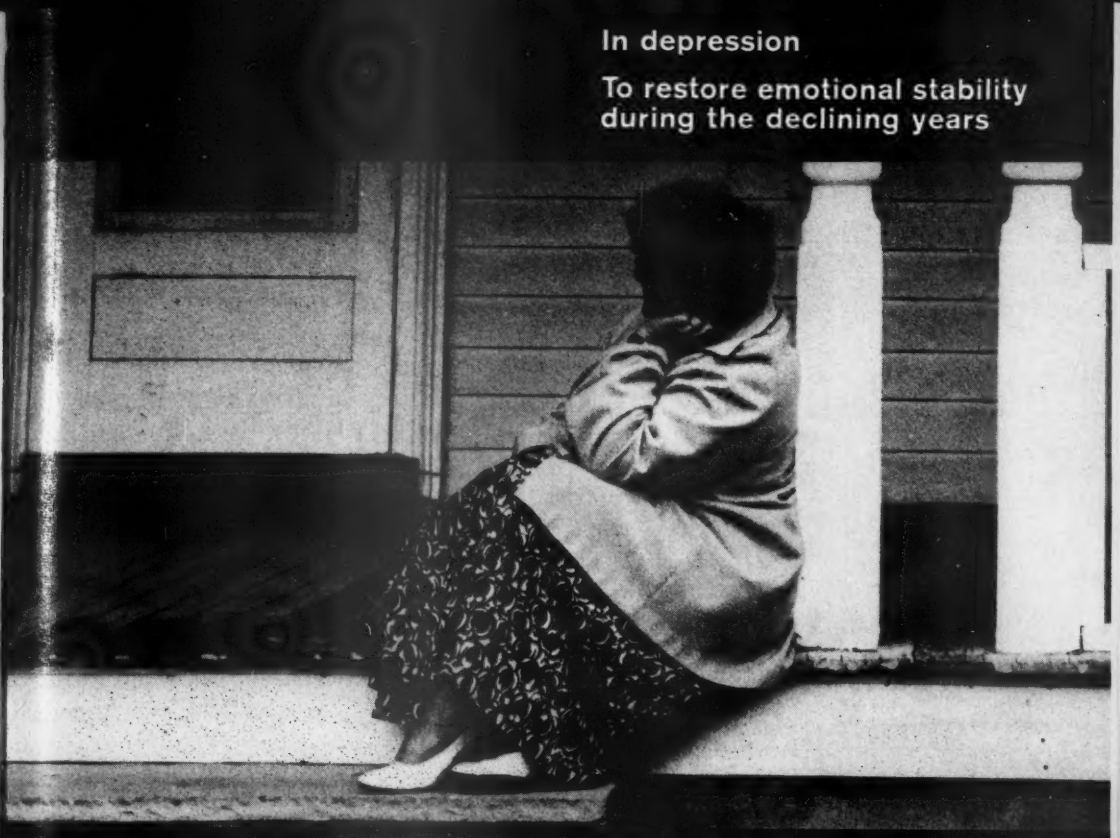
Psychosomatics, the official organ of The Academy of Psychosomatic Medicine, was founded in 1960. It is published bi-monthly, the volumes beginning with the January-February number.

Articles appearing in this Journal do not necessarily reflect the official attitude of the Academy or of the Editorial Board.

The subscription rates are $10.00 to the volume; foreign subscriptions, $11.50, including postage.

Business communications, remittances and subscriptions should be addressed to Psychosomatics, 277 Broadway, New York 7, N. Y.

Editorial communications, manuscripts, books for review, and exchanges should be addressed to the Editor, Wilfred Dorfman, M.D., 1921 Newkirk Avenue, Brooklyn 26, N. Y.



In depression

To restore emotional stability during the declining years

Tofranil

brand of imipramine hydrochloride

Thymoleptic

New for geriatric use

Tablets of 10 mg.

Recent studies[1] strongly indicate underlying depression as a causative factor, and Tofranil as an eminently successful agent, in restoring the difficult geriatric patient to a more contented frame of mind and more manageable disposition.

1. Cameron, E.: The Use of Tofranil in the Aged, Canad. Psychiat. A. J. Special Supplement, **4**:S160, 1959. 2. Christe, P.: Indications for Tofranil in Geriatrics, Schweiz. med. Wchnschr. **90**:586, 1960. 3. Schmied, J., and Ziegler, A.: Tofranil in Geriatrics, Praxis **49**:472, 1960.

Also Available:

For the treatment of non-geriatric depression: Tofranil tablets of 25 mg. and ampuls of 25 mg. in 2 cc. solution.

Geigy **Geigy**, Ardsley, New York

all of these patients have anxiety symptoms;

*but <u>half</u> need an antidepressant, not a tranquilizer

depression—a common problem in office practice...

"It is generally acknowledged that at least 40 to 50 per cent of the patients seen in private practice have emotional problems and that true depressions or depressive equivalents are found in more than half of these." Cooper, J. H.: J. Am. M. Women's A. *14*:98[illegible], 1959

anxiety often "masks" underlying depression...

"Although ataractics have a definite place in therapeutics, their use in depressed states is limited, and in many cases even contraindicated. A large number of patients with psychogenic disorders are given ataractics for the relief of anxiety symptoms. Since the anxiety is actually due to depression, the response, if any, is transient and occasionally the patient may become worse...." Hobbs, L. F.: Virginia M. Month. *86*:692, 1959

IN DEPRESSION AND DEPRESSION-INDUCED ANXIETY

the common problems basically unresponsive to tranquilizers

Nardil®

brand of phenelzine dihydrogen sulfate

relieves the anxiety by removing the depression itself

WARNER CHILCOTT
MORRIS PLAINS, N.J.

supplied: Orange-coated tablets, each containing 15 mg. of phenylethylhydrazine present as the dihydrogen sulfate. Bottles of 100.

Complete Nardil Bibliography on request to the Medical Department.

[illegible]

VOLUME I · NUMBER 6 NOVEMBER · DECEMBER 1960

PSYCHOSOMATICS

Official Journal of The Academy of Psychosomatic Medicine

Round Table Discussion on Psychosomatic Medicine: Definitions, Goals, Limitations, Assorted Conflicts and Dilemmas

WILFRED DORFMAN, M.D.
Moderator

In opening this summit conference, I should first warn the audience that this is the only panel scheduled where the participants were not asked to prepare formal papers. It was planned that way to help provide a greater degree of spontaneity and informality—with the possibility of losing out on the obvious advantages of adequate preparation.

Since the field of psychosomatic medicine claims many territories, some fairly adjacent, and others far afield and fairly deep in left field, it was felt that prepared papers could never hope to anticipate the needs of this particular audience. Many of you are generalists, others are specialists in every field of medicine and surgery. Some of you are involved primarily in research; some are psychiatrists and a few are psychoanalysts. All of you may have different expectations of what you will hear tonight. So I may say at this point that if you don't hear what you want—send your questions up and we'll try to get them answered.

As the moderator, I must admit that I have steeled myself to expect almost anything. There is nothing more frustrating to a moderator than having a top-notch panel of experts with no questions to answer. So I prepared a number of pertinent questions to help stimulate both the panelists and the audience. With a bit of luck, perhaps two or more of the panelists might be stimulated, hopefully in different directions, so that their real feelings will be exposed. We can always read the erudite, edited and expurgated version of the discussions emanating from both the panelists as well as the audience which will some day appear in *Psychosomatics.*

I hope each of the panelists will choose some particular area of my remarks as a point of departure for his own five minute presentation. Or, if you prefer, choose your own special topic from this vast field of Psychosomatic Medicine. According to the late Dr. Zilboorg: "Psychosomatic medicine is overburdened with problems which medicine cannot yet solve and which psychiatry can only name."

The first question I pose to the panelists is to furnish a definition of psychosomatic medicine. This would be very helpful. Another question that naturally follows: Is every illness psychosomatic? Or is this term reserved for only a chosen few? Is psychosomatic medicine a specialty? Or is it a philosophy, an attitude, an orientation, a way of thinking essential for every physician?

Then I would like to consider where to place the emphasis on psychosomatic—if it is primarily to the left—on the psyche, or primarily to the right—on the soma, then how do you keep your orientation when faced with somatopsychic reactions?

Presented at a Round Table Discussion, 7th Annual Meeting of the Academy of Psychosomatic Medicine, Oct. 13, 1960, Philadephia, Pa.

Or are some of you delicately balanced at dead center on a sharply picketed fence?

Are psychosomatic conditions primarily psychogenic in their etiology, and pathogenesis, and should treatment be limited only to manipulation of the psyche? What is the role of genetic, constitutional, enzymatic, biochemical, immunological and other somatic factors? How about cultural factors?

Do you believe that specific types of personalities or specific types of conflicts produce specific diseases or are you more convinced of the role of the autonomic nervous system? Are patients with psychosomatic disease more prone to neurotic or pre-psychotic behavior? Is it true that patients with ulcerative colitis never get hypertension, or vice versa? What makes psychosomatic illness reversible in many instances and irrevocably irreversible in some others?

In the approach to the treatment of psychosomatic illness, what are the goals for the non-psychiatrist? the psychiatrist? the psychoanalyst? To what extent can psychiatry and medicine be integrated? How can the non-psychiatrist be intelligently oriented to cope with the vast amount of emotional disturbances that he sees in his daily practice? How long does it take to properly orient him? Why so long?

How about the psychiatrist? What about his attitudes, thinking and approach to the treatment of patients with psychosomatic illness? Is he immune from scientific scrutiny? If he has had the benefits of a "training" analysis, how long does it last? Is there a possibility of recurrent or persistent blind spots? You all know that scotoma can scintillate and yet produce a good sized blind spot.

What about the limitations in the treatment of psychosomatic illness regardless of who does the treatment? Plato, the philosopher, in 450 B.C. noted the low cure rate in his fellow Greeks at an academy meeting in Athens and made an impassioned plea for physicians to treat both the body and mind. We can't expect that a philosopher, without medical and psychiatric training, could understand the dangers that may be present in rapidly removing somatic symptoms. But it should be common knowledge for the physician of today to realize that the severely emotionally sick patient with a duodenal ulcer can occasionally become depressed if he is "cured" too rapidly, so that a little heartburn may be a wonderful temporary compromise. Likewise weight reduction in an emotionally unstable person may precipitate an acute depression or a schizophrenic episode. Other examples of this can be seen in women following simple childbirth, after simple surgery such as a herniotony, or following plastic surgery. What is your experience in this area?

What are the dangers in orienting the non-psychiatrist psychiatrically? Will he attempt to do too much? How can this be prevented? My experience in the seven years since the inception of the Academy has been that these dangers have been significantly reduced rather than increased. The goals of the Academy have been clearly defined at our annual meetings and in our official journal, *Psychosomatics*. They include the encouragement of the physician, irrespective of his field of medical practice, to effectively utilize a psychiatric orientation, but this has been constantly accompanied by the most necessary orientation that there are limitations—and that we all have them.

Various types of psychotherapy are utilized by various types of physicians. What will psychotherapy by the adequately trained psychiatrist achieve in patients with peptic ulcers, coronary disease, obesity, arthritis, bronchial asthma, dysmenorhea, sterility, frigidity and many other illnesses? How does the non-psychiatrist feel about this?

And now for a few final questions. First the question of psychiatric referral. What

results can be anticipated? Some reports indicate that one third get better, one third remain the same, and one third get worse no matter who treats them or whether they are treated by psychiatrists or not. Is this tri-partite division fair? Or do we all see different types of patients because we attract them in relation to our different orientations or labels?

How about some practical points for the busy doctor? How can he work out the special time requirements for the handling of patients with emotional problems? Is a fifty minute hour absolutely essential for all patients? All the time? Is a couch necessary? Can too much time and too much probing create additional problems? Should the doctor feel justified in charging higher fees if patients demand or require additional or more than the usual time? What are we going to do to facilitate the treatment of patients with meager economic resources who need urgent treatment? How about the many patients with adequate financial resources who can't wait weeks to see a busy psychiatrist?

I trust that the audience will begin to prepare questions as we go along. These can be directed to any of the panelists.

If some remain unanswered, perhaps it is best related to the fact that there may be no glib answers available rather than to blame it all on a lack of time. At any rate, there is still the hope that some of your unanswered questions can be answered next year at our meeting in Baltimore.

Although asthma of psychic origin cannot be differentiated clinically or histologically from that due to pollen or food, the role of emotional states in precipitating an allergic reaction has been recognized. . . . Situations such as the return of the mother to outside employment were often equated with loss or threatened loss by the asthmatic child. . . . While these losses might threaten any child, they are not usually followed by a physical reaction unless the trauma strikes constitutionally determined and emotionally fertile ground. . . . Rorschach studies revealed that asthmatic children, as a group, were characterized by traits of anxiety, dependency and insecurity. . . . Psychiatrists point to the existence of excessive interpersonal tension in the home, particularly between mother and asthmatic child. . . . The need for closeness in the asthmatic child conflicts with the child's natural tendency toward further emotional growth and development. . . . Only removal from the home, such as hospitalization, can lead to improvement.

Psychosomatic Aspects of Asthma in Childhood.
(*Pictoclinic, Ames Co., Elkhart, Ind.*, Vol. 6, #8.)

Comprehensive Psychotherapy

JULES H. MASSERMAN, M.D.

Dr. Wilfred Dorfman's very kind introduction recalls the reply that my revered teacher, Adolph Meyer, once made when he was placed under similarly laudatory but slightly embarrassing circumstances before a public lecture. Said he, stroking his goatee reflectively: "Praise . . . is like smoking: warm, pleasant and relaxing. And I suppose it does no harm—if you don't inhale!" On the other hand, Dr. Dorfman's remark that he had tried for three years to induce me to address this young and dynamic organization would have reference to a quite different anecdote about a minister who, after services one Sunday, confided to a woman in his congregation of whose virtue he was becoming dubious: "Miss ———, I prayed for you two hours last night." Replied she: "Oh, you needn't have done that, reverend. Next time just pick up the telephone and I'll be right over." But now that I am here, let us also get down to the fundamentals: in this case, what we must comprehend (grasp and put together) if we as therapists are truly to serve (Gk. *therapein*=service) our patients and humanity in general.

It is somewhat startling, but it may very well be, that most of the technics we use to help ill and troubled human beings can be summarized under three headings. Forgive me if these sound a little oversimplified, but in a field where there has been so much over-obfuscation, oversimplification is a welcome relief. May I propose that we can attempt to control our universe in only three ways? First, we can try to control material things, and so reassert our technical mastery of the physical universe. Second, we can collaborate with our fellow human beings and so establish collaborative friendships. Or, third, we can resort to a transcendent system of beliefs, whether we call it science or philosophy or metaphysics or theology, and so find order and security in an otherwise chaotic universe. That these three methods have been used ever since life was created is an historically demonstrable statement. But we have a peculiar attitude toward history, particularly in our current American culture. H. J. Muller has perhaps expressed it most trenchantly in his aphorism that here in America our concept of history seems to be confined to the minutes of the last board meeting, and that we neglect the precious lessons not only of half a million years of human development, but of three billion years of biological evolution.

In contrast, may I point out that at least three billion years ago, in the primal Algonkian slime where life was created, almost immediately it showed two of the properties that I mentioned: first, a capacity to maintain itself by manipulating the inorganic elements of the universe; and second, a kind of collaborative effort. Even in the most primitive organisms that have survived until now, we do not find the philosophy of the tooth, the fang and the claw, which is a misrepresentation of scientific evolution. Instead, even so relatively simple a creature as the myxameba, which is nothing but a blob of protoplasm, collaborates with and dies for its fellows. The single cell may remain a rugged individualist, providing everything is going relatively well; however, should its environment dry up, should

---

Presented at the Seventh Annual Meeting of the Academy of Psychosomatic Medicine, October 15, 1960, in Philadelphia, Pa.

Professor of Neurology and Psychiatry, Northwestern University Medical School, and Director of Education, Illinois State Psychiatric Institute, Chicago.

The field is similarly reviewed in "Humanitarian Psychiatry," *American Practitioner,* (Nov.) 1960, portions of which are hereby reprinted by permission of George F. Stickly, J. B. Lippincott, Philadelphia.

food become scarce, what will it do? It will congregate with others to form a colony. Some cells may deliberately die to form themselves into a stalk upon which the others can feed, sporulate and survive.

In slightly later stages of evolution, say the physalia organisms such as the Portuguese man-of-war, it is difficult for an evolutionary scientist to tell whether these are just simply collections of individuals, whether they are colonies, whether they are an organization in the sense of a town functioning apart, or whether the whole constitutes an animal. We humans also are operating with certain inherent biological and biodynamic wisdom through which can be stated as follows: We still overcome our insecurities by relearning how to handle the universe materially and we still overcome our social anxieties by banking on a biologic heritage of living friendships.

If we are now to skip three billion years minus, say, fifty thousand and come up to the earliest records of humanity, the third principle becomes almost immediately apparent. Let us take the oldest record we have of human behavior, say the Mousterian caves of fifty thousand years ago. Of course we have the artifacts of these primitive people, who had the brain potential and all of the physical endowments we have today, plus their stone axes, scrapers, throwing darts and so on, with which to manipulate the universe. At the same time they had already reached a high level of social development and were gregarious and friendly. They lived in caves, not only in familial groups of enforced friendships, but also in gatherings of clans and tribes. They joined in common endeavors with apportioned roles and organizations. They apparently took care of their aged; they certainly took care of their children or else we would not be here to philosophize about it at all. They used then the two principal technics we still use today: the employment of mechanical skills, and the utilization of human communication and fellowship. But almost immediately, also, we have a third: a system of beliefs not only in tomorrow but in a universal order and in a hereafter. How do we know all this? History was written fifty thousand years ago, not in pen and ink but in deathless stone. We have, for example, those unlovely but unforgettable little stone statuettes called Paleolithic Venuses, with physical features of unmistakably exaggerated womanhood and motherhood. What do they represent? They are really a kind of tribute to universal gentleness, a form of mother worship epitomized by the ancient goddess Ishtar, Isis and all the beneficient mothers of men. In addition to that, we find works of art expressing not only man's creative strivings but also a trust in man's capacity to determine his own future. You've all read of the wonderful drawings and paintings in the caves of Altamira in Spain and Lascaux in France, in which the tribal hunt was represented. There is no deliberate cruelty in these pictographs; they were simply the collaboration of human beings in a common endeavor for the good of the clan. But they were also placed in alcoves very much like primitive chapels, in remote regions of the common cave, and surrounded by articles of worship. Thus, through form and ritual, they represented man's dreams and hopes in a sense that, if he depicted the future in the poetry of his own imagination, he could thereby control it.

Have we learned very much since then? It seems that the basic principle by which men live, by which they obtain security and which we now employ in what we call psychotherapy, had already been determined. Man's physiology had been established as had the basic pattern of the central nervous system and his resistance against disease. So also had he set up his social defenses. You can very well imagine a Neanderthal man troubled or lost, coming home to the cave, being accepted into a society of his fellowman, being reassigned a role and feeling once again secure

—provided, of course, he fitted into the technological and cultural requirements in the organization of his society, participated in its philosophy and, if you will, its primitive theological-religious system.

Certainly, then, throughout history we have had these three principles put into effect with versatility and finesse. The first requirement was to solve physical difficulties by developing technologic skills, from spade to sputnik. If you had floods on your farm, you built a dam; if your hut fell, you built a better one. However, if you really needed help you had a right to call on your fellow human being to consult with you about the nature of your difficulties and to join with you in solving them. If specialization were needed, then you called on a shaman who was both a physician and a priest; indeed, only very recently, have these two functions been separated, and then only formally, not really. This gentleman then applied his special knowledge and skill to solve your problems, at the same time employing his magical powers, his knowledge of the absolute, to see to it that your divine servants in heaven also helped you as beseeched or commanded.

By the time of ancient Egypt many of these technics had achieved a high degree of reliability. You came to the temple when you were ill or frightened. There you went through certain rituals. These involved various mechanical devices which gave you a feeling of mastering physical objects. At the same time you met with people with problems similar to yours and you consulted with them. Also, and most important, you found a haven of refuge in a hospice or "hospital"—a special place of healing connected with the Temple. There you slept; there you were fed and there you were given drugs that "tranquilized" you and you fell into a gentle sleep. During that sleep you had dreams which you did not understand but which the priest explained to you. He then told you what troubled your soul. He also gave you certain kinds of advice which, if followed, would purportedly not only solve your problems here on earth but also in heaven.

By the time we come to the Greeks, there is hardly a technic that we use today that was not used in what might be called the Golden Era of Humanitarian Psychiatry. A Greek who was really troubled, who had difficulty with his family, with his business, with his associates or with his systems of thought, would first of all leave the place where his difficulties had become unbearable. He would repair to a temple of peace called an Asclepiad Sanatorium. This temple of healing was located in some remote region away from trade and war and stress, in a salubrious climate among beautiful surroundings; it was a haven of refuge from the difficulties and conflicts of daily living.

The name Asclepios, by the way, is an intriguing one, as are the names of his lovely daughters, Hygeia and Panacea. Asclepios himself had an interesting genealogy. He was the grandson of Apollo, and Apollo was the God of Medicine, of music and of science. In this connection, I might point out that Apollo is a most appropriate God of Medicine; since what could better represent the average doctor than somebody as wise and as handsome as Apollo? Apollo had a son, however, who seemed to be a little out of line because he was a centaur, half man and half horse, by the name of Cheiron. As a physician, I always wondered why he belonged in our lineage until I remembered that my average working day is about fourteen hours. I imagine most physicians work about that long, and so you see you *have* to be half man and half horse to be a physician. But please remember which half was the head.

Thus Asclepios, the son of Cheiron and the patron saint of medicine, gave his name to these sanatoriums. And well he might, because in them was practiced all that was best for us, not only from the

standpoint of science but from the standpoint of humanitarian understanding. I have already mentioned that the hospitals were located in places that would appeal to almost anyone who wished once again to experience aesthetic delight in the communal love of nature. But this was only the beginning. The troubled pilgrim was met not by a secretary or a receptionist but by the high priest or priestess, representing an authoritative parental welcoming of the prodigal son returning home, where direct and immediate comfort was offered. For example, much attention was paid to the patient's diet: he was fed, and fed exceedingly well. Care was taken of his ablutions; he was bathed and he was massaged. He was put to bed to rest, and given medicine to reduce his anxiety. The drugs were called "nepenthics" rather than "ataractics," and there was no technical talk of physiotherapy, balneotherapy, pharmacotherapy, etc.—but the purposes were pretty much the same and the effects all the greater.

What, then, was happening to this troubled human being who wanted to escape from the responsibilities and sorrows of adult life? He was literally welcomed back home and permitted to become once again a dependent, relaxed child, given a good deal of comfort and reassurance and warmth and human acceptance. This, it is true, we still try to do, although the doctors, busy with "deeper techniques," very often leave these essential first steps to others. The Greeks, however, were also a great deal wiser than we are in later stages of therapy. They recognized that a precipitate retreat to infantile dependence, though a necessary stage of gathering strength for a new base of operations, may in itself become an escape and a handicap. Therefore, instead of making this mistake (one we often make now in our so-called "anaclitic" therapy in which we literally baby the patient indefinitely, or in our misuse of the analytic couch where people may become fixed in a horizontal position for a baby-sit of five or six years, or in various other kinds of retreats from reality) the Greeks almost immediately began to use a rehabilitative program designed to restore the patient as soon as possible to social functioning. As one of many methods, they began to use what has always been a universal form of communication—music. Now music is one of the most meaningful and transcendant kinds of communication. It mobilizes a sense of belongingness in an orderly universe, a sense of harmony, a progression toward logical solution, a working together through blended effort and a reaching for aesthetic perfection. But the Greeks knew this well, more than I can tell you, and made it part of their philosophy; for example, the Pythagoreans employed numbers and music as the basis of life and reality. And so the patient, before he regressed too deeply, was called back by the harmonious strains of music to more mature thoughts and communications.

And much else was done. For example, the patient's personal problems might be depicted in the wonderful plays written by Aeschylus, Euripides or Aristophanes, in which the most fundamental of human relationships were acted out, such as those of Oedipus, Narcissus, Medea, et al. These human relationships are deathless and therefore give the plays even today their poignant meaning. But the Greeks approached them in a more dynamic fashion than we do because, as you know, they did not simply sit and watch and criticize. They joined in. There was a chorus; the actor and the audience were very much more in communication and even interchangeable, and so each person felt as though he were sharing in each human tragedy and comedy and reaching his own solutions by these vicarious means. Today we call it psychodrama or associative drama, or the spontaneity stage or whatnot. Is there anything new in it? As a matter of fact, in Aristophanes' "The Clouds," there is a wonderful scene in

which a troubled human being comes to a philosopher called Socrates. Strepsiades, the patient, is told to lie on the couch, to think completely freely and thereby to reach an understanding of his problems by this apparently indirect technique. But Strepsiades does not know exactly what his troubles are. He just simply knows he does not sleep well nights and is tense and anxious. Socrates directs him not to lie on the floor but on the couch (*klinikos*) and then to simply say anything that comes into his mind. Strepsiades begins to talk, of all things, about the moon, and Socrates says in effect: "That's all right, go ahead and talk about the moon if you want to." And it turns out through a series of free associations that this brings to mind the fantasy that if Strepsiades could only capture the moon and put it in his pocket, that might solve his financial problems since if it would not wax and wane, the first of the month would not come around and Strepsiades would not have any debts to pay. And thus it was that the problem was analyzed and insight acquired; unfortunately, then as now, there is no mention of a cure.

More seriously, the Greeks also acknowledged that there are certain holy areas of thought that should not be desecrated, and even they, scientists that they were, made Socrates drink hemlock because he dared to question the power of the gods. They recognized that human beings must have beliefs and systems, and whether or not they glorified what was best in humanity, these systems must be respected and not desecrated. They therefore placed their temples of healing next to temples of religion and thereby added the powerful tools of joint beliefs, joint rituals and joint appeals to beneficient deities—something we do not always do now. And when the patient left the sanatorium, the Greek physician, being humanitarian, was fully willing to collaborate in directing his patient for advice and guidance to the priest of his own choice in mundane as well as heavenly matters. Have we improved on anything since then?

During the Middle Ages, the Church offered a haven of refuge that humanity sorely needed as a retreat from the difficulties of a very conflictful world. The Church was a center of learning and of knowledge and of medicine. It offered a haven of brotherhood and sisterhood to which all could adhere. It had to protect that system, of course, and sometimes was a little severe and ruthless in protecting it, but all churches of various categories and denominations, are alive today simply because they fill a fundamental human need which will persist as long as humanity.

When only three centuries ago psychotherapy began to pretend to become "scientific," it is interesting that the first two self-designated "scientists" were actually downright quacks. The earlier of these "healers" who proclaimed that he could cure human beings without the aid of divine intervention was a chap by the name of Greatrakes the Stroaker, who lived in the seventeenth century. He would "stroake" people in such a way that somehow the noxious humors in their bodies would be forced out of their extremities. True, he lived in the post-Cromwellian era, which was a rather difficult period; also, he was an Irishman, and of course Irishmen sometimes overdo contacts with each other. In any case, he had thousands of people flocking to his clinic to be stroked. Why were they there? Because in a difficult world where most contacts were murderous rather than gentle, they found somebody who supposedly knew what he was doing, who would pat and comfort them much as though they were children. They would find fellow believers in his system, which was the "science" of the day. With their common belief, their common group activity and a jointly revered healer, everyone was helped. And so do thousands of people who believe in chiro-

practics or osteopathy or Swedish massage, or Yogi exercises or yogurt cheese, get a very great deal of comfort out of going for their respective brands of "stroaking." Not because the massage or the "adjustments" or the baths or the calisthenics or the rotting proteins have anything to do with the cure, but because the faithful are very much like troubled children who are hurt and frightened, and whom mother reassures and pets and plays with and feeds until they feel better.

A century and a quarter later lived the founder of a great many of our modern therapeutic techniques—another quack by the name of Anton Mesmer. He, too, had his "science." (Incidentally, I wonder what people will think of *our* psychotherapeutic "science" a hundred years from now?) What Mesmer noticed, however, was that people could affect each other at a distance; that is, when he himself made certain movements with his hands he could influence others without touching them. Now what forces act at a distance? There were only two known as the time: gravity and magnetism. So Mesmer gravely figured there must be a kind of animal magnetism that had to do with touching an object and then waving one's hands and thus producing effects at a distance. Since the same sort of gravity-magnetism seemed to set the planets in their course, naturally his so-called science was also connected with the effects of the planets on people, i.e., astrology. (For that matter, Kepler, one of the greatest astronomers of all time, was also an astrologist.) Thus did Mesmer set up a system which was highly successful therapeutically. Under Mesmeric influence, people would fall into trances, dream, have highly emotional reactions, and awake claiming to feel not only very much better, but exhilarated and euphoric.

Mesmer undeniably entranced a great many influential people, and was therefore for a time highly successful and fashionable. There were international Mesmeric societies; with international Journals of Mesmerism. If you were properly Mesmerized by a properly Mesmerized person, and you had a certain number of controlled Mesmeric sessions, you could enter the local Mesmeric Society, after which you were an accredited Mesmerist. And then you could treat people according to the Rules; however, if you sought new and better methods, there was a good deal of discussion about your loyalty and therefore your professional qualifications. Of course, Mesmer was quite sincere in his theories, and felt himself martyred by the medical men of the day, who with Benjamin Franklin, had called him a quack. Indeed, he died convinced that he had discovered a universal system of healing—and so he had, in the sense that he had once again tapped a basic human yearning for encounter and relationship. Not "animal magnetism" (later called hypnotism), but the kind of communication that had been practiced in the temples of Egypt. There, too, in a setting of diminished light, with a central altar upon which attention was concentrated, the priest had intoned a repetitious, monotonous, rhythmic lullaby known to all mothers of troubled children who need reassurance and rest in a trusting security. Intuitively, when we are approached by troubled people, we still talk in this kind of soothing, monotonous, cadenced tone of voice. Predictably also, Mesmer's practice grew so great that he could not give individual attention to every patient, so he began to deal with them in groups. Mesmer's patients would form a circle, hold hands, feel overpowered by the "magnetism," fall into trances, have an intensive "corrective emotional experience" and leave praising the system and spreading the Mesmeric gospel.

From Mesmer arose a great many of the systems that we can now call by their modern names. First is the wearing of "magnetic belts." Have you any idea of how many belts are sold in the U.S.A. by

mail order houses and so on? Hundreds of thousands of people still wear a kind of "magnetized" diaper around their middle beneath their clothes and swear that it cures all sorts of diseases.

Second, we have a current school of hypnotists who, in their theorizing if not in their practice, try to avoid the simple fact that people like to be comforted, like to feel safe, like to feel as if they are being treated by a magically wise and powerful person; consequently, some professional hypnotists themselves seem to operate in a sort of trance. In this connection, one of the greatest of hypnotists, a physician by the name of Bernheim who taught Freud, wrote perhaps one of the most penetrating commentaries on hypnotism. Cautioned Bernheim: "It's a darn good hypnotist that knows who's hypnotizing whom."

A third derivative of Mesmerism is the Christian Science Church, which invokes some of the most powerful principles of human behavior known to psychiatry. These include first, a system of transcendant beliefs, not only religious but purportedly "scientific"—the two most powerful systems of thought. Second, the Church offers an almost universal kinship; there are three thousand Churches of Christ Scientist, so you can hardly feel alone anywhere in the western world. Third, the Church offers a very simple, repetitious and assertive dogma, completely self-confident in its obscurity. So also, the services consist of readings from Mary Baker Eddy, endlessly reiterated, so if you learn a few key phrases, you know all of it. Furthermore, think of the vast power with which Christian Science healers proudly believe they are endowed. I have to see and work with people in order to do something with them in my practice. But then I am not a Christian Scientist, who can heal at any distance with what is apparently a divine power. This, of course, is comforting to all concerned but me. Nevertheless, a great many lost, troubled, lonesome human beings join not only Christian Scientist churches but many organizations with similar beliefs and practices and thereby find precious comfort and security. No one can deny the tragedies that can result from the misapplication of such doctrines, but no one can gainsay how much comfort can also be given to hundreds of thousands of people. And as humanitarian psychiatrists, we can neither neglect nor deny anything that concerns our patients.

But there is another derivative of Mesmerism that seems at first sight almost completely scientific—modern-day psychoanalysis. And yet its evolution, too, though a long story and a somewhat discursive one, can be summarized for our present purposes in the light of what we have said. Freud began by using hypnotism to command his patients to tell him what was troubling them, i.e., the directed confessional. But since many patients refused this form of "cooperation" (you coo while I operate) Freud granted his patients greater freedom, and simply invited them to say anything and everything that came to their minds without fear of condemnation or judgment. And so of course they would tell him, often with appropriate histrionics, about what they wanted him to think troubled them. This Freud called "catharsis," in the sense of ridding the mind of something noxious, and "abreaction" when the emotionality was intense and therefore presumably corrective. And of course, some patients got better because they thought here was a man who was interested and understanding, but at the same time not judgmental or punitive; ergo, they had in effect found a friend. But Freud went on from this to deeper recognition: namely, that these people must have been chronically troubled long before the trivial happenings to which they attributed their current difficulties; in other words, they must have been sensitized by preceding unfortunate experiences, perhaps in childhood. And

true enough, most patients began to talk about their adolescence and eventually their childhood, to the effect that events then had rendered them particularly sensitive to hurts and to rejections and to corresponding sorrows in later life. Many patients also began to talk about their family relationships and certain unfortunate insecurities, jealousies and conflicts in that sphere. And so for a time psychoanalysis consisted of an attempt to recall and reconstruct childhood "traumata," particularly the so-called "Oedipus complex" and other "libidinal conflicts."

Then Freud also began to recognize something that almost every minister, physician or other advisor had implicitly observed—that the therapist is inevitably put by the patient in the role of some sort of parental or other surrogate or substitute. The patient thus attributes to the therapist certain characteristics that he does not necessarily possess, and then treats him as a mother, or as a rival, or as an erotic object, or as a source of suspicion, or as a protector who must look after the patient indefinitely, or in various other roles involved in the patient's interpersonal relationships. Therapeutically, once the patient recognizes the artificial positions into which he forces not only the therapist but various other people in his life, he may correct these interpersonal misinterpretations by the use of a more realistic approach. Freud called this "transference analysis," by which he meant simply that the patient transfers to his therapist, whether that therapist be a physician, a priest, a friend, a Dutch uncle, a corner druggist, or a hospital aide, certain important human relationships meaningful to the patient and which the therapist should understand and help to correct. This is about where Freud stopped, but by this time he had already rediscovered and reformulated (sometimes unnecessarily fancifully and obscurely) various basic principles of human behavior and clinical therapy that have been operative throughout the ages —and, of course, need still be applied if any form of treatment, including psychoanalysis, is to be effective.

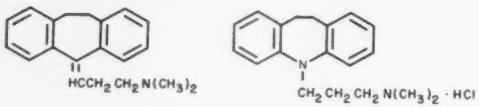
Since then, of course, we psychiatrists have employed a great many other approaches, none of them new. We have rediscovered the efficacy of re-establishing control of the material universe through "occupational" therapy, job training, and so on. We have rediscovered the necessity of progressive social rehabilitations through making a hospital not a place apart from the rest of the universe but an intimate part of the community. And then we have rediscovered the intimate relationships between psychiatry and the various religious systems. In our own peculiar American way, we immediately commercialized this so that there are now Institutes of Psychiatry and Religion, richly endowed, of course, by our government but which I am afraid, might again become over institutionalized and over "committee-ized" and thus perhaps lose the humanitarian substrate on which they were founded.

Does this brief review give us any idea of the deep meanings of "humanitarian psychotherapy"? I hope so. There is one difficulty with it: we have been able to look briefly only at a skeletal outline, and as I have remarked somewhere, only an archeologist can be really interested in skeletons. But you can clothe the skeleton with the living tissues of your own human experience, and render it alive and vibrant. Thus, all of us from all walks of life may recognize that in our love for our fellowmen we have in all our dealings with each other, also always been humanitarian psychotherapists.

Amitriptyline (Elavil) Therapy for Depressive Reactions

FRANK J. AYD, JR., M.D.

Antidepressants may be divided into those which inhibit brain monoamine oxidase (Catron, Marplan, Marsilid, Nardil, and Niamid) and those which do not (Tofranil). Because of the established antidepressive activity of Tofranil other compounds which possess the same pharmacologic spectrum yet differ in certain specific ways have been studied to discover new antidepressants which may have fewer side effects and enhanced therapeutic effectiveness. This has led to the development of Elavil (amitriptyline). Structurally, Elavil resembles Tofranil and, pharmacologically, both have a similar spectrum of activity. This report is concerned with the clinical findings in a fourteen-month study of Elavil to ascertain its clinical indications, dosage, side effects, and therapeutic activity and to compare it with other antidepressants.



AMITRIPTYLINE (ELAVIL®) IMIPRAMINE (TOFRANIL®)

Figure 1.

CLINICAL MATERIAL

Elavil was prescribed for 130 office and hospitalized patients (72 men and 58 women; ages 23 to 77) whose predominant symptoms were: depressed mood, psychomotor retardation, loss of interest, feelings of guilt, insomnia, anorexia, and functional somatic complaints. Diagnostically, they were classified: manic-depressive depressed (59); involutional melancholia (22); schizophrenic reactions with depression (17); and neurotic depression (32). Included in this group were 90 patients who had never received an antidepressant and 40 patients who had prior antidepressant therapy. The latter comprised 14 patients who recovered from an earlier depression when treated with Tofranil (5), Marplan (5), and Nardil, (4), and 26 patients who had not responded to Tofranil (5), Marplan (5), Marsilid (5), Nardil (6), and Niamid (5). Clinically, some were retarded; others agitated or anxious. All took Elavil from 2 to 9 months.

Every depressed manic-depressive with the exception of nine who were ill for the first time, had a history of two or more depressions from which they had recovered following electroshock therapy (EST) or drug therapy. Thus it was possible to compare the response of the same patient to Elavil and EST or another antidepressant.

The involutional melancholias included 13 retarded, 6 agitated, and 3 paranoid types. Of these, four (2 agitated and 2 paranoid) had not reacted to or were made worse by EST.

Among the depressed schizophrenics were 9 schizo-affective reactions, 5 pseudoneurotic, and 3 paranoid types. Aside from two patients with schizoaffective reactions of recent origin, all had been ill for at least two years. Nevertheless, their personalities were well preserved. They were given Elavil because they were incapacitated more by their depressive symptoms than they were by their primary ailment.

The neurotic depressive reactions consisted of 8 psychoneuroses, depressed type, 17 obsessional neuroses, and 7 obsessive-compulsive neuroses. Some were depressed for the first time, but most had had repeated transient episodes of mel-

Chief of Psychiatry, Franklin Square Hospital, Baltimore, Maryland.

Elavil is the trademark of Merck, Sharp & Dohme for amitriptyline.

Read at the Seventh Annual Meeting of the Academy of Psychosomatic Medicine, Philadelphia, Pennsylvania, October 13, 1960.

ancholia. The former were primarily stress-precipitated acute reactive depressions. All had depressions of sufficient severity or duration to warrant therapeutic intervention. In none was a spontaneous remission anticipated in the immediate future on the basis of their clinical picture.

TECHNIQUE OF THERAPY

The starting dose of Elavil was based on the clinical estimate of the severity of the target symptoms; subsequent dosage was increased or decreased by increments of 25 to 50 mg. a day within two weeks depending on the clinical response and tolerance of the individual patient. The effective initial daily dose was 75 to 150 mg. orally and 80 to 120 mg. parenterally. In addition to the antidepressant, some retarded depressives were given Dexedrine (5-10 mg. daily) or Ritalin (20-40 mg. daily). All schizophrenics, whether agitated or apathetic, and every anxious, agitated non-schizophrenic took a phenothiazine derivative concomitantly with Elavil. Whenever insomnia was severe, barbiturate hypnotics also were prescribed.

Parenteral Elavil was administered to hospitalized patients 2 to 4 times a day. The briefest period of use was 3 days; the maximum 16 days. No unusual local tissue irritation was noted as a result of these painless injections.

The criteria for improvement were: (1) marked improvement—total disappearance of depressive symptoms; (2) moderate improvement—25 to 75% modification of target depressive symptoms. By these standards after two months of Elavil therapy, the improvement rates were: improved 31%, partially improved 48%, and unimproved 21% (Table I).

TABLE I

Comparison of Therapeutic Results with Various Antidepressants

	Patients	Improved	Partial Imp.	Unimp.
Drug	No.	%	%	%
Elavil	130	31	48	21
Tofranil	100	25	48	27
Marplan	100	27	34	39
Nardil	100	28	32	40
Niamid	100	24	31	45

An analysis of these therapeutic results disclosed that when Elavil helped, improvement began in the first month, often within three days. The earlier a beneficial change occurred, the better was the ultimate outcome; the longer it took for therapeutic action, the poorer was the final result. Also, the smaller the dose needed to elicit improvement, the more optimal was the result; the larger the dose required for benefit, the less favorable was the ultimate outcome. Less than 10% of patients required more than 150 mg. daily; the maximum being 250 mg. Doses of above 150 mg. a day were seldom beneficial and were accompanied by an increase in the incidence and severity of side effects, especially in elderly patients in whom such doses produced intolerable side reactions. Failure to improve within three months indicated the need for some other therapy, even though an occasional patient responded to further treatment with Elavil. Thus, Elavil parallels Tofranil closely in speed of action and effective daily dose.[1]

Optimal therapeutic results almost always were achieved in manic-depressives with a mild depression, providing their pre-depressive personality was cyclothymic or obsessional with a minimum of neurotic traits. These patients complained, not of melancholia, but either of physical symptoms or of feeling apathetic and indifferent. They usually responded early to small doses of Elavil.

Equally gratifying results were obtained in the mildly depressed manic-depressives who were lethargic and seldom had physical complaints, except that they were slow responders. These patients complained of feeling inadequate, lacked confidence, were disinclined to carry on their usual activities, expressed mild ideas of unworthiness, were doubtful, fearful,

and tended to avoid people. To them, everything was an effort. When urged to do things they became peevish and obstinate. Usually their symptoms developed insidiously and gradually progressed. Many dubbed themselves "tired businessmen" or "tired housewives."

Moderately to severely retarded manic-depressives also responded favorably to Elavil. Those with a relatively stable personality prior to their depression and in whom the depression appeared abruptly usually reacted best, their improvement appearing within 2 to 4 weeks. On the other hand, those whose pre-depressive personalities contained many neurotic traits, whose depression developed insidiously, and who had a history of prior long-term depressive attacks were very slow reactors requiring three months of Elavil therapy for benefit.

Anxious and agitated manic-depressives responded as well to Elavil as retarded depressives, providing they took a tranquilizer along with it. Some severely agitated depressives were treated with combined EST-Elavil-tranquilizer therapy because of the suicide risk. In most cases, fewer shock treatments were needed than when the same patients were treated with EST alone in prior depressions. Similar results were reported by Dorfman.[2]

There are manic-depressives who have an attack every Spring or Fall and who continue to work despite their diminished efficiency and enervation. Some resort to amphetamines to restore their energy level and elevate their mood; others drink more alcohol than usual to buoy their spirits and are known as periodic alcoholics. They are notoriously resistant to EST in the early phase of their depressive cycle, but respond to a few shock treatments after they have passed the nadir of their depression and are on the way to a spontaneous remission. Those treated with EST combined with Elavil responded early and with fewer treatments, but Elavil had to be continued until the depressive cycle was complete or they relapsed. Others reacted favorably but slowly to Elavil alone.

For years EST has been the treatment of choice for involutional melancholia. This now may be said for Elavil. Whether it was administered in the early stages of the attack when the patient was troubled by progressive physical and mental fatigue and a declining interest in and capacity for his usual pursuits or when he had reached the stage of insomnia, agitation or retardation with hypochondriacal obsessions and feelings of guilt, the outcome was generally excellent. Less favorable results were secured in involutional depressions with marked paranoid features unless combined Elavil-tranquilizer therapy was employed.

Reactive depressions may or may not respond to Elavil. Those patients with early morning awakening and retardation were most likely to react favorably, especially if they had rigid obsessional personalities. Dramatic therapeutic results were seen in those patients often diagnosed anxiety hysteria because their depression was overshadowed by severe anxiety with hysterical features. Most of these were middle-aged women who had good pre-illness personalities despite an anxious, phobic temperament. In contrast to the classical endogenous depressive, these patients had a normal sleep pattern or insomnia which readily responded to barbiturate hypnotics, rather than an early morning awakening. Usually they complained of feeling worse as the day wore on. They had little appetite disturbance and no great weight loss. They had many somatic complaints. Seldom were they self-deprecatory. They detested being alone, were voluble, anxious and tremulous and exhibited psychomotor stimulation instead of inhibition. Frequently their illness followed a period of stress. Tranquilizers invariably made them feel worse. EST enhanced their anxiety, and if given several shock treat-

ments they complained of memory impairment which was really a feeling of estrangement. They had marked subjective awareness of this "memory loss" and abhorred EST. Often they voiced fears of losing control, of screaming, of making a spectacle of themselves, of harming others, and of going insane. When treated with Elavil they reacted promptly, often within the first week. However, they had to take this drug for three or more months after apparent maximum improvement or they relapsed.

The response of obsessional neurotics to Elavil depended on their pre-illness personality and their symptoms. Those patients who prior to their depression had a normal energy level obtained optimal benefit; those who were anergic before their depression did not. The older the patient and the more integrated his predepressive personality the more favorable was the outcome of Elavil therapy. The best results were obtained in those patients whose depression unleashed obsessional-ruminative tendencies, torturing phobias, and symptoms of depersonalization. Young obsessionals with masked paranoid and schizophrenic tendencies under the influence of this drug became obviously paranoid and schizophrenic. Depressed obsessive-compulsive patients did not respond well to Elavil, especially when ritualistic behavior was prominent. In fact, most of these patients were made clinically worse by Elavil.

Schizophrenics, in particular, needed combined Elavil-tranquilizer therapy to minimize the danger of activating overt, aggressive behavior. None of the manic-depressive patients in this series swung from a depression to mania. Nevertheless, there is a need for close supervision of patients treated with Elavil.

Included in therapeutic failures were a few people who began to respond, then relapsed and were resistant even to large doses. Invariably these patients did not begin to improve until after the fourth week. Clinically, they were neurotic depressives, more often chronically ill than not, who had multiple somatic complaints and who had reacted similarly or not at all to prior antidepressant therapy, including EST.

A comparison of the therapeutic results in those given Elavil combined with Dexedrine or Ritalin with those on Elavil alone showed no significant difference between the two groups. The analeptic did seem to diminish subjective awareness of enervation, but once Elavil began to take effect the analeptic could be discontinued without loss of therapeutic gain. In a few instances the analeptic seemed to catalyze the stimulating effect of Elavil to such a degree that a tranquilizer had to be substituted for the analeptic.

A check of the five patients who had recovered from a prior depression with Tofranil revealed that four reacted just as well to Elavil, while of the five patients who previously had not responded to Tofranil, three improved on Elavil. Likewise, of the five patients who had remitted from an earlier depression when treated with Marplan, three improved on Elavil, while of the five patients previously resistant to Marplan, four recovered on Elavil. Of the four patients who had responded well to Nardil in a former depression, two responded similarly to Elavil and two did not, while three of six patients who did not benefit from Nardil did react well to Elavil. Also, three of five patients unresponsive to Marsilid and four of five patients resistant to Niamid improved on Elavil.

Of the 90 patients never treated with an antidepressant, 13 did not react to Elavil. These were then switched to Tofranil and 10 were equally resistant to Tofranil, while three improved partially.

The combination of Elavil and an amine oxidase inhibitor was tried in 10 patients. This disclosed no evidence of synergistic action with regard to side effects or therapeutic results. The incidence and severity

of side effects were the same and the therapeutic results were no better than those obtained with one antidepressant. Although there were no difficulties encountered in combined Elavil-amine oxidase therapy, this form of therapy is discouraged because it has little or no therapeutic advantage and because of the risk of untoward reaction similar to those reported in some patients treated with a combination of Tofranil and an amine oxidase inhibitor. Admittedly, these reactions have been rare, but when they have occurred they have been serious and, in some instances, fatal.

Although Elavil has lessened the need for EST, on occasions shock therapy combined with this drug has been employed. This combined treatment is safe, and the evidence to date strongly suggests that it reduces the number of shock treatments required.

When Elavil has been effective it cannot be stopped until the depression has resolved. Discontinuation of the medication before three months after maximum improvement invites the risk of relapse. Ideally, dosage should be lowered gradually and the drug not withdrawn until the patient has been well for four to six months. A resurgence of depressive symptoms may occur when the dosage is reduced, necessitating resumption of the previous therapeutic dose for several more months.

It is apparent that prolonged Elavil therapy will be needed for many patients. This raises the question of the safety of long-term treatment with this drug. A comparison of the pre-treatment hematologic and liver function studies (alkaline phosphatase, cephaline flocculation) with the same laboratory tests after three months in 50 patients showed no significant difference.

SIDE EFFECTS

The side reactions to Elavil and a comparison with those due to other antidepressants are tabulated in Table II. Elavil caused weakness and fatigue, drowsiness, dizziness, dryness of the mouth, blurred vision, constipation, and muscle tremors. In many patients Elavil-induced drowsiness was advantageous; in a few this had to be counteracted for a few days by Dexedrine or Ritalin. The type and frequency of side effects were related partly to dosage but mainly to individual susceptibility. Every patient had some somatic reaction to this drug, but some had many on very low doses and others had a few minor ones on very high doses. Moreover, some individuals had side effects early; others only after they had taken the medicine at least two weeks. Age influenced the incidence of side reactions, since the older the patient the more likely were they to occur, especially constipation and muscle tremors. Thus the side effects of Elavil are similar to those caused by Tofranil. However, the side reactions to Elavil caused, generally speaking, less subjective discomfort in patients than Tofranil. This was especially noted by patients who had been treated with both drugs.

Most side effects of Elavil were not serious, seldom required counteracting measures, and subsided as the drug was continued. Some side effects caused sufficient subjective discomfort, however, to warrant either remedial action or prompt discontinuation of the drug.

The blood pressure response to Elavil was variable and unpredictable. All patients with systolic pressures below 100 mm. Hg. showed no change or a rise in blood pressure. Most normotensive patients had no blood pressure alteration, while some had a slight rise or a slight drop. Likewise, the majority of hypertensive patients had no blood pressure change, while some had an average decrease of 20 mm. Hg. and a few a slight rise in pressure. To date, no patient treated with Elavil has had postural hypotension.

COMMENT

The findings in this study reveal Elavil to be an effective antidepressant with clinical properties somewhat similar to Tofranil with respect to speed of action, dosage, type of side effects, and therapeutic effectiveness. Although the pharmacologic basis for the therapeutic activity of these two substances at present is unknown, the demonstration that agents structurally similar have the same pharmacologic spectrum is helpful in correlating pharmacologic activity with clinical utility.

There are many parallels between Elavil and Tofranil, but there are some clinical differences which influence their clinical indications and therapeutic usefulness. Two important facts emerge from this study. Generally the side effects are less severe with Elavil and hence more patients can tolerate this drug than Tofranil. Also, patients unresponsive to Tofranil may react favorably to Elavil and vice versa. Much more clinical work is needed to learn the subtle difference between these two drugs. Meanwhile, Elavil is another effective antidepressant which broadens the scope of depressive reactions susceptible to chemical amelioration.

TABLE II

Side Effects Due to Antidepressants

	Elavil	Tofranil	Marplan	Nardil	Niamid
Number of patients	130	100	100	100	100
	%	%	%	%	%
Headache	6	15	12	12	10
Dizziness	20	36	40	42	3
Blurred vision	20	20	26	20	2
Dry mouth	60	42	36	40	4
Postural hypotension ..	0	2	8	6	2
Epigastric distress	4	8	14	18	2
Constipation	60	40	10	30	3
Diarrhea	0	2	2	0	1
Delayed micturition	0	2	3	2	2
Altered erotic desires ..	0	7	9	6	1
Impotence	0	2	1	2	0
Weakness and fatigue	20	34	37	30	9
Edema	0	0	4	2	1
Sweating	16	33	9	12	4
Muscle tremor	6	9	0	0	0
Dermatitis	0	2	1	0	0
Inc. psychomotor activity	0	1	0	2	0
Hepatomegaly	0	0	1	0	0
Insomnia	4	3	5	4	0

SUMMARY

During a fourteen-month period Elavil, a new antidepressant structurally related to and pharmacologically similar to Tofranil, was administered to 130 office and hospitalized neurotic and psychotic patients with depressive symptoms. After eight weeks of treatment, 31% were improved, 48% partially improved, and 21% unimproved or worse. The most effective therapeutic daily dose was 75 to 150 mg. Symptomatic response occurred usually within one month, often as early as the third treatment day. Side effects were mild and disappeared spontaneously or when dosage was lowered.

Like other antidepressants, Elavil was especially effective in endogenous depressions and less beneficial when the depressed patient had many neurotic traits. In many respects this drug is similar to Tofranil but its side effects cause less subjective discomfort and it appears to have a greater therapeutic activity.

BIBLIOGRAPHY

1. Ayd, F. J., Jr.: *Jour. of Neuropsychiatry*, 1: 1-4, Sept.-Oct., 1959.
2. Dorfman, W.: *Psychosomatics*, 1: 3:153-155, May-June 1960.

Prevention Goes Hand in Hand with Treatment

C. L. WILBAR, JR., M.D.

When an antibiotic is administered to a patient with syphilis, is the patient mainly being treated for disease or are the serious tertiary effects of this disease being prevented? When an individual with rheumatic fever is given penicillin during the acute stages of the disease and for a period thereafter, is he primarily being treated for his disease or is the drug being administered to prevent rheumatic heart disease? When a person with tuberculosis is treated in a sanatorium, is it chiefly to get that individual well or to prevent the spread of the disease by him to other persons? When an individual with diabetes is placed on a dietary regimen and given insulin as needed from time to time, is his schedule mainly administered to treat a disease or to keep him well and prevent gangrene or blindness or any of the other serious complications of diabetes? Many more such illustrations might be given which indicate the difficulty of separating "treatment" from "prevention." In the field of prevention, however, there are great gaps between scientific knowledge and widespread application of this knowledge. This is true in spite of widespread attempts at popularizing preventive measures. Educational measures toward the use of an antipoliomyelitis vaccine have been tremendous in their scope. Popular education, such as use of newspapers, radio, television, pamphlets, brochures, movies and lectures have been repeatedly used to urge individuals to be vaccinated against polio. Still little more than half of the people in the nation who should have this immunization have availed themselves of it. Likewise, who has not frequently heard of the value of periodic chest x-rays, or tuberculin testing plus x-rays, for early discovery of tuberculosis and that tuberculosis can be cured if discovered early? Yet, over fifty per cent of the patients entering the tuberculosis sanatoria in this state have their tuberculosis in a far advanced condition at the time of admission, and this is not an unusual pattern throughout the nation.

Much effort has been expended to bring about popular understanding about diabetes, its easy discovery and the fact that an individual with this disease can live a long and healthful life by keeping his diabetes under control. Yet it is rather accurately estimated that only about half of the diabetics in the country know that they have the disease and diabetes is the eighth leading cause of death in Pennsylvania.

For all other diseases where preventive measures are effective, no snowfall of popular educational materials has covered the country, as in the cases I have cited, but a great deal has been done. The three leading causes responsible for most of the blindness in our nation, are cataracts, glaucoma and diabetes. The blindness resulting from these conditions is very largely preventable. In the case of senile cataracts, the removal of the opaque lens and the substitution of glasses constitutes the preventive measure. Yet, studies by the National Society for the Prevention of Blindness indicate that the older the individual, the less apt he is to allow himself to have his eye operated on for a cataract; this in spite of the facts that the older he is the more apt is he to have a cataract, and that regardless of age modern cataract surgery is successful surgery. In the case of glaucoma, which causes twelve per cent of the blindness in

Secretary of Health, Commonwealth of Pennsylvania.

Presented at the 7th Annual Meeting, Academy of Psychosomatic Medicine, Philadelphia, Pa., October 14, 1960, as part of a panel on "Handling the Patient with Chronic Illness."

our state, periodic examinations to determine increased eyeball tension or reduced visual fields can discover insidious glaucoma. When discovered in its early stage, medication or in some cases surgical procedures, are exceedingly effective in preventing the blindness from this disease. It is estimated that two per cent of all persons over forty years of age suffer from glaucoma. Here, then, is the second leading cause of blindness obviously not being detected and treated in time, for it is a type of blindness that is almost entirely preventable. I have already spoken about diabetes and its complications, including blindness.

I could give many other illustrations where the well proven knowledge of health scientists is far from being adequately applied popularly. Few preventive measures have been so thoroughly explored and accurately tested as the benefit of adequate fluoridation of water in preventing tooth decay. This measure has been well proven to be effective and safe and it is a relatively inexpensive process. Scientific and health organizations of the highest caliber and integrity, including the American Dental Association, the American Medical Association, the American Public Health Association, the National Academy of Sciences and most state and local health departments, as well as the United States Public Health Service, have endorsed this preventive measure. Yet again, throughout the country, considerably less than half of the public water supplies which do not have adequate fluoride originally are being treated to bring the fluoride content up to the small amount needed for protection against this widespread ailment of our people—tooth decay.

I might give one more example of inadequate application of knowledge in the rehabilitation area. The so-called cerebral accident group due to hemorrhage or thrombosis of the blood vessels of the brain, popularly known as stroke, constitutes the third leading cause of death in most states. It also causes many thousands of cases of disability. Today, thousands of persons, particularly those in the older age group, are needlessly bedbound and home-bound because of lack of knowledge and therefore, lack of application of rehabilitation procedures aimed against the results of stroke. It is, of course, true that not all individuals who suffer a cerebral blood vessel accident are able with the best of modern rehabilitation procedures to recover to the full extent of their previous ability. However, it has been demonstrated time and time again that with the proper rehabilitation, application of physiotherapy, graded exercises and educational procedures, most stroke patients do not have to be invalided and can regain at least a large portion of their former ability. The United States Public Health Service has a major educational program called "Strike Back at Stroke," but one does not have to look far in chronic disease hospitals and nursing homes or homes for the aged to see how inadequately this program is being applied.

We still have some activities today in the public health and preventive field which take action by a governmental organization, such as sewage treatment, treatment of water supply and fluoridation of water. However, the health records of the nation show that communicable and infectious diseases are no longer the major problems they formerly were. The chronic diseases have come to the fore as the leading maimers and killers. Seven out of the ten leading causes of death, including the first three, are chronic diseases. In these diseases measures for preventing the acquisition of the disease, for long term recovery from its ravages, or for living with the disease for years in a not uncomfortable existence, all call for action by the individual. If he doesn't take the action, he generally does not pass on his disease to others, although he may cause others financial and individual

worry about his condition. These conditions call for a personal, individual to individual type of education for successful understanding and application of necessary preventive measures. I believe we have demonstrated that widespread "everybody-do-it" type of education has been only partially successful. It is difficult through this type of "shotgun" education to get individuals to take time, effort and funds to look for disease conditions which do not seem to be threatening them at the time.

The Commission of Chronic Illness has stated, "Individual initiative is vital in the prevention of chronic disease. The medical and dental professions should encourage physicians and dentists to practice preventive medicine and dentistry aggressively and enthusiastically. In health supervision of their patients they should provide such services as: appropriate immunizations; judicious use of antibiotic drugs in the early treatment of streptococcal infections to prevent rheumatic fever and possibly acute nephritis; individual health education directed towards cultivation of personal habits and practices that are conducive to good health such as maintenance of optimum weight and avoidance of excessive smoking."

Some of this person to person education is done by public health nurses, sanitarians and nutritionists. There are few of them, however, whereas most individuals go to physicians from time to time for treatment of their ills. They have a great deal of confidence in the recommendations of their individual physicians. Thus, the practicing physician becomes a key person in the education of individuals to prevent chronic illness. If he is alert to his role in this regard, he can be very effective in reducing the mortality, morbidity and economic loss from chronic illnesses.

Studies have shown that less than ten per cent of individuals ever visit their physicians when they are well for a check-up. I believe the physician is the key person in increasing the percentage of persons who seek out their doctors for keeping well. If the practicing physician uses the visits of his ill patients to indicate to those patients the great advantages of keeping well and if he is conscientious and patient about taking time to perform health maintenance examinations, including certain laboratory screening tests, many of the chronic diseases which we now know how to prevent can be reduced to a minimum, the health of our population greatly enhanced and its life span greatly increased.

This is, of course, not an easy program nor one which will occur over night. We know that in the past the teaching of preventive medicine in medical schools has often been a sorry thing. Even today, the effectiveness of such teaching varies from school to school. It is something that cannot be taught in the department of preventive medicine alone; to be adequately understood it must be integrated into all the teaching departments of the school. The thought that the doctor is as much responsible for keeping people well as for treating them after they are ill has apparently not yet struck a responsive chord in the minds of all of our medical educators. Graduate education must provide this training for those physicians who did not receive adequate training in this field in medical school.

I do not wish to leave the impression that I believe that simple pronouncements by the physician to his patients and to individuals as to what they should do to keep well will of necessity motivate the patient to do them. Methods which work with one patient will not work with another. Human behavior differs considerably from person to person. This makes life interesting, but it makes mass education difficult. The same approach to this type of education cannot be used for both the coal miner and the lawyer; for the waitress and the school teacher; for a

member of one racial group and another; for the older person and the younger; for the farm resident and the city dweller. In this regard, we all need help from the psychiatrist and the behavioral scientist. There are educational procedures for different types of individuals in different types of communities. Public health workers are turning more and more to the behavioral sciences to learn how to motivate different groups of people to take the actions necessary to keep themselves well. Having maximum physical, mental and social well being and a long life are very popular in the abstract, but when it comes to the sacrifice of some other, perhaps more pleasant activity to achieve them, the motivation factor becomes more complex. The person who drives an automobile with his small daughter in it at 75 miles an hour certainly has no desire to kill or maim his daughter. But all too often his sense of value becomes beclouded due to the thrill or desire of the moment, thus emphasizing the difficulty of applying the long term discipline needed to prevent accidents or chronic disease.

The physician, whatever his specialty, is almost invariably called upon to perform some other community services in the preventive and public health field. He is called upon to help determine policies for public agencies in the health field, both governmental and private. This includes serving on boards such as boards of health, school boards, and governing boards of the various voluntary health agencies. In the broad area of occupational health the practicing physicians work hand in hand with industry and labor to keep the worker healthy and safe. In some instances, there is full-time employment by physicians in occupational health, but there are many small industries and organizations which employ physicians on a part-time basis to help in various aspects of their occupational health program. The physician then must guide management and labor in good health principles.

The medical profession is making concerted efforts in behalf of sound measures to reduce the cost of medical care. The public does not always appreciate this fact. Certainly, aggressive efforts in our own communities to bring about programs which will reduce the incidence of disease, retard its progress, and mitigate its effect will greatly help to reduce the dimensions of the socio-economic problems of medicine.

In some ways each physician's office is a small local health department, for the physician is generally considered by his patients to have the ultimate answers in the health field, whether they be treatment or prevention. I believe treatment and prevention are indistinguishable from one another and need to be continually intermingled in daily practice, with constant attention paid to the fundamental aspects of each of these in dealing with our patients and communities.

How do I work? I grope.—*Albert Einstein.*

A Note on the Hostility Component in Pathological Blushing

JEROME M. SCHNECK, M.D.

In a previous contribution on the psychopathology of blushing and erythrophobia I summarized their occurrence as an expression of excitement in reaction to a sexual suggestion or reference, an indication of conflict over exhibitionism, a reflection of concern over sexual strivings, and fear about possible discovery of masturbation.[1,2] In addition, I described a patient whose blushing and erythrophobia involved problems of masochism and exhibitionism, guilt in connection with sexual expression, fear of discovery and being judged.[2] A supplementary finding was that in certain settings the blushing was representative in parallel and substitutive for sexual reaction and orgasm. Study of other patients, two of whom will be mentioned now, has revealed that blushing serves at times as an expression of, and defense against awareness of strong unconscious feelings of hostility.

A thirty-year-old unmarried man, satisfactorily active sexually, complained of troublesome blushing and erythrophobia in work settings. He was embarrassed and perplexed. It was discovered that blushing occurred in reaction to happenings involving others toward whom he felt quite hostile. At such times he did not recognize the nature of his feelings or the reasons for them.

A 27-year-old unmarried woman blushed frequently in a variety of settings and was able to explore in treatment the underlying elements outlined earlier, referable to sexual issues. On many occasions they seemed not to apply and this left her puzzled and disturbed. Further exploration revealed the blushing and erythrophobia to be accompaniments of strong unconscious feelings of hostility.

The blushing as a reflection of unconscious hostility, striving for expression but held in check for fear of exposure, must be distinguished from facial flushing that accompanies conscious feelings of anger and rage. The flush is evidently part of a more generalized cardiovascular response.

Beyond their practical interest for therapy and general interest for study of personality, these observations suggest a note on theory. The blushing appears at times to be an extension of the functions of integumental tissues as biological weapons for physical attack and defense. Phylogenetically, the self-preservation role was of major significance, with the danger concrete and apparent. In pathological blushing the reaction combines measures of attack and defense embodied in surface tissue with its vascular support. The functional barrier appears to be atavistic in this context. Psychological rather than physical forces are at play. The conflict is internal rather than external. The blush is inadequate for aggression or defense operating on an unconscious fantasy level only. As a result it largely reflects anxiety without allaying it. The hidden hostility component may sometimes be exposed and an effort made to deal more concretely with underlying conflict.

Clinical Associate Professor of Psychiatry, State University of New York College of Medicine at New York City.

26 West 9th Street, New York 11, N. Y.

BIBLIOGRAPHY

1. Fenichel, O.: *The Psychoanalytic Theory of Neurosis.* New York: W. W. Norton, 1945.
2. Schneck, J. M.: *Psychoanal. Rev.*, 43:111, 1956.

Group Therapy in Private Practice of Psychiatry

JACK SHEPS, M.D.

Therapy in a group setting offers conditions which facilitate dealing with certain constellations of emotional problems. As this is a form of psychotherapy, it should be undertaken only by the practitioner committed to psychotherapy—that is to the use of the emotional participant relationship of doctor and patient.

Group therapy requires great skill and patience because the emotional interactions of many patients must be noted simultaneously. The therapist becomes a real participant in each patient's emotional reactions, not just an observer, and he must be willing to share his own emotional reactions with the patients and to demonstrate healthy responses to feelings of guilty fear, anger, rejection and inferiority, as distinguished from neurotic adjustment.

In the group, as demonstrated by Ackerman,[1] genuine social experience is provided. The impact with reality is immediate, and the reality is continuously being asserted by the group. Irrational attitudes and expectations, magic, omnipotent fantasy and irrational motivations are expressed but are reacted to and checked by the group. The group accepts the patient's feelings, sympathizes with them and, to some extent, shares them. Thus, a high degree of social communication and expression in social action and reaction are achieved, with each patient developing the feeling that he 'belongs.' As the patient no longer feels so unique, he is encouraged to a higher degree of acting out and consequent discharge of tension. Dependency needs are now divided among the whole group and not exclusively directed to the therapist. At the same time, fear of the therapist as an authoritarian figure diminishes as the patient feels he has allies.

Group conditions favor psychotherapy of the borderline psychotic and schizoid character disorders, the persons "prone to schizophrenia,"[3] since these patients develop a crippling dependency on and fear of the therapist, as they do with all authority figures, with very great distortion of reality and difficulty in achieving flexibility of social role. These patients have always denied their feelings, especially their anger at frustration, and are completely unaware of how they manipulate others in order to keep themselves in a perpetually helpless, frustrated position. In individual treatment alone, an impasse usually occurs because the patient fears his treacherous, unpredictable parent (whom he has projected on to the therapist) and views all of society in this violent light. Not only does the patient feel his emotions violently when the controls are released, but he sees the responses of other people in terms as violent as his own. This is rarely expressed, with emotional conviction, in individual treatment; but with the therapist's authority and power diluted in the group, where the patient feels he has allies, he gradually overcomes his fear at recognition and expression of his violent feelings.

In the group, the therapist observes social role ("that externally oriented part of the personality")[2] in action. He points out provocative behavior and directly interprets repressed emotions by breaking through the denial of feelings. The patient's fear diminishes when he can express his feelings without the threat of abandonment or murder, because he has allies in the group.

Patient W. tested his fear of expressing anger, first toward the prettiest

A different version of this paper was read at the 1959 meeting of the American Psychiatric Association, Section on Private Practice, on April 29, 1959, in Philadelphia.

woman, using the rest of the group as allies. Then, he became angry at all the women, using all the men as allies. Next, all the men in the group were targets of his anger, with all the women as allies. Finally, he expressed his anger at the therapist, with the whole group as allies. At each stage he succeeded in getting some expression of agreement with his anger from some group members.

A preliminary period of individual therapy alone is necessary to build up a relationship of trust so that the patient can feel the therapist will protect him in the group. Common resistance that the other patients are too sick to help him or that they are strangers who are not interested in him are really expressions of his fear of not being accepted by the group. However, social anxiety is one of the complaints which brings a patient to treatment, and if enough positive feeling for the therapist has been established, the patient's hurt at being moved from the favorite 'only child' position to one of the siblings will be tolerated. Individual sessions must be continued, however, at least once a week, so that the therapist can continue his exploration of the patient's total adaptation and verify his opinion as to the motives behind his social roles. The patient's relationship to the therapist, both in behavior and material presented, often differs in the group from that in individual sessions. One patient stated that he felt like a lion in the group because he had allies, but that he had to act like a sweet little boy in individual sessions.

There are many variations, and reversals, of the typical role where the patient is more outgoing and self-assertive in the group. This is very profitable because his feelings and behavior are apparent to the others and therefore cannot be intellectualized or denied by him. Some group members develop a sensitivity to each other's unconscious; thus acting as auxiliary therapists.

At the outset, it is made clear to the patient that he does not have to answer any questions he does not wish to answer, but he cannot demand that others answer all of his questions. The therapist is free to use any of the material he has unless the patient wants to withhold certain facts from the rest of the group. His wishes, of course, must be respected. However, discussing this can be very helpful in uncovering his distrust of the therapist.

The group is usually composed of seven or eight patients, with five and ten the outside limits. It should be large enough to get a good range of interaction, but not so large as to be unwieldy. In private practice, the continuous group is the most practical because it offers a state of change for every member and a preparation for constant growth and self-development. Guilty fears and feelings of inadequacy are common to all patients, and feelings about self-image and the reality of life, as the patients see it, soon dominate the group sessions. People are different enough in handling these basic issues so that any group can interact, and it is not necessary to restrict the choice by age, sex, education, social status or complaint, as long as cultural attitudes admit of sufficient common ground. In order to promote group interaction and prevent siphoning off of material in small sub-groups, socialization before and after sessions is not permitted. Anonymity is preserved at the beginning, but later is left to the individual's discretion. Patients develop a sense of responsibility to each other and usually carry out the agreement to be honest with one another, confident that their interests will be respected. Obviously, this criterion excludes psychopathic personalities, the severely depressed, and actively hallucinating patients, with no insight. Seating arrangements are optional; distractions should be minimal—no telephone or other interruptions unless they are emergencies.

The group is dedicated to the proposi-

tion that all of its members are part of the whole. The withdrawal of any member from the circle, either into the center or away from it, is a signal for the therapist to call attention to this and to the interaction that has led to it. "Going around" is a technique introduced by Wolf[4] where the members, each in turn, give their feelings about an interaction. This is useful when there is no response to the therapist's interpretation and he feels there is considerable denial or suppression of feeling. All the techniques and principles of individual psychotherapy are applied to specific situations, and the experienced psychotherapist, if he has the courage to let himself become involved, will soon find that he is as much at ease in the group as in individual sessions.

Case Material

Case S. This patient, 26, an only child and a talented composer, came to treatment because of social and sexual inhibitions and dissatisfaction with his work. He had a duodenal ulcer and marked pyloric and intestinal spasm. He spoke in a low, soft voice, with a moderate stutter present since the age of 14.

During the first year of treatment (four individual sessions a week) his fear of me was acted out by coming late and taking the wrong elevator. He accepted my interpretations that the nature of his acts, as revealed in dreams, identified me with his father who would not allow him independent feelings or thoughts but that he could not bring these feelings into awareness and, therefore, felt intense diffuse anxiety.

After a year in treatment, his somatic symptoms disappeared. He had an affair with a very passive girl, with good performance and enjoyment, and was attempting to earn more money. However, after a thyroidectomy for removal of a benign, non-toxic adenoma, S. found himself unable to date women and he was placed in the group 14 months after the start of treatment.

In the group he was silent and uncommunicative for the first few sessions, after which he attempted to interpret the feelings of other group members. He identified one as a man like his father, who felt different from most people, unlovable and undeserving of love—a failure. He then began to feel and communicate emotion more directly in individual sessions, expressing rage against his mother for not defending him against his father. As he expressed his longing for, incorporation of and rage against his mother in individual sessions, he was able to speak more freely in the group. He told me he identified everyone in the group with his father; they are dangerous, intolerant people who will harm him if he seeks pleasure.

Some time later, another patient (D) told the group that he was afraid to tell me about his pleasure during intercourse. All the group members, including S., pointed out to D. that they had the same problem. In the next individual session, S. said he never could feel close enough to me to ask my help in increasing his sexual pleasure. He felt I would rebuff him and then he would be angry. He continued his identification of me with his father, stating that my pipe smoking meant that I needed a woman's breast and that he and I were competing for it.

In the next individual session, S. more directly expressed his anger at me with fantasies of grabbing me by the throat. "You are like my father who said to me when I was little, 'You can get along without your mother's breast' and now you say the same thing." In the subsequent individual session, for the first time, S. experienced directly a powerful emotion. This was his fear of certain abandonment and desolation if he completely expressed his rage. That evening, in the group, patient D. criticized several group members, accusing them of not telling the truth. Patient H., a very dogmatic, self-righteous person, seconded him and was attacked for his authoritarianism by patient L., a middle-aged woman.

In the next individual session, S. expressed resentment at D., who like his father, wants all members of the group to please him. He identified H. as his mother who kept him helpless and deprived. He realized he blames his mother for his present loneliness and isolation and finds himself very angry at her all the time. In the following individual session he reported a dream in which he was a mad dog tearing people to bits. "I will murder if my rage gets out. I had to get the fear of separation out before I could express my full rage at my mother. I feel the group now accepts my problems."

The patient could accept his murderous rage toward his mother after: 1) His identification with group members, as having similar problems, took him out of the world of the nursery where he was the only child, and gave him allies. 2) He reacted to L. as the loving mother who protected him against the authoritarian H., unlike his real mother who would not be on his side versus his father. Assured of mother's love, relieved of his fear of abandonment and reassured because she was not afraid of father's rage, he was able to release his anger against her (the bad mother).

In a subsequent individual session, S. related

a dream in which his mother was a spider who made a gesture of love and choked him. His murderous anger at his father made him unlovable to her because she was a helpless person who needed her husband. If he revealed love for his mother it would infuriate his father. S. said he felt he had to prevent his father from getting "mad" at him; otherwise his father would kill his mother and him.

I had to cancel an individual session, on short notice, because of a personal emergency; in a group session later that day, S. said he wanted to punch me in the nose for cancelling his appointment. He also said he felt that he could take over the sessions and do a better job than I was doing. Feelings of superhuman strength then became the theme of individual sessions. The patient's voice dropped several tones and developed a buzz-saw quality. "I could just cut you and everyone who gets me mad into pieces." He expressed the conviction that I don't want him to have sexual pleasure because my rules of group behavior prevent him from having intercourse with patient L. (the good mother). Then he identified me as being similar to his father. "You will be nice to me up to the point that ethics and training force you. Then you will put your foot down like my father and say 'just do it my way.' First I thought I'd get up and slit your throat. You'd be dead, but all my friends would be jealous of my independence and attack me like you do."

Discussion of Case S.

With the expression of omnipotent feelings, S. began to understand his inability to show love for his mother—in order to avoid his father's murderous rage and perpetuate the nursery situation with his parents. This new insight enabled S. to feel, with emotional conviction, his murderous rage to kill both his mother and father as representatives of the whole adult world. Only the gathering of allies in the group and a feeling of acceptance by a loving mother-figure who stood up to his "murderous father" enabled him to overcome his fear of abandonment.

S. has begun dating more attractive girls and has become more aggressive in trying to sell some popular songs he has written. He also has sought pupils for music lessons. His voice is deepening and his speech hesitation is now barely perceptible. Emotions are much more genuinely felt, and dreams can be utilized to lead to a direct awareness of emotion. Although dreams still show defenses against the expression of feelings toward his own self-determination, these are now readily recognized and their roots are subject to evaluation and correction.

In the group, the common emotional constellations present themselves very differently at times, but the same principles obtain: inadequate self-image in a hostile, treacherous society, where the price of love is pain; fear of taking responsibility for one's actions and lack of commitment to one's existence. All of these emerge, along with the patient's anger at the frustration of his infantile demands for care and magic. The group lessens this anger by making explicit, through its very existence, that complete possession of the magical parent (therapist) is impossible, thus forcing the patient to face his feelings of anger, despair, or futility at ever attaining independence. The therapist's task, of course, is to direct and guide the group toward this goal. Often, it is useful, therapeutically, for a patient who wishes to leave the group to explore with them his reasons for wanting to leave and his conception of mental health.

Generally speaking, about two-thirds of the borderline psychotic or schizoid patients who fail to make progress in individual therapy alone benefit from combined group and individual therapy, and it should be considered when the therapist feels an impasse has been reached or when he is dissatisfied with a patient's progress.

I have spent the main body of this presentation discussing the borderline cases because, today, they form the great majority of cases seen by the psychotherapist in private practice. This is especially so since drug therapy has sufficiently improved many chronic patients, formerly in mental hospitals, for them to return to the community.

At the other end of the spectrum are milder cases of maladjustment. Here, adaptation is on a good level and the patient uses his abilities and takes advantage of his opportunities. This patient's self-image and conception of the world, and his infantile, dependency needs are not so distorted as to require extensive individual treatment. Usually, after a few

interviews the relationship is good enough for him to be placed in a group and seen individually once a week until the therapist feels he has a good understanding of the patient; the patient is then seen individually only occasionally. If this type of patient does not work well in the group, his resistance, and possibly the therapist's, should be explored. With these milder cases, group therapy offers some economy of time, but even though individual sessions are few they are needed to assess the patient's current adaptation and define his goals of treatment.

Midway between these extremes, viz., the borderline and the slightly disturbed, are the usual run of neurotic cases, many of whom are extremely difficult to treat because of their denial of feeling. However, obsessional and phobic patients often benefit from the adjunctive use of group therapy and may be placed in either group, depending on their base line of dependency. For these patients, concurrent individual sessions are just as important as with borderline cases.

Although there are many differences of opinion among eminently qualified psychotherapists who do group therapy, it is being used today, to advantage, to treat a wide variety of the cases seen in private practice. I feel that it is not, as is thought by some, a treatment that fails to deal with the patient's basic problems, or one in which more patients are treated in less time. Combined with individual therapy, it offers an opportunity for a level of treatment not otherwise possible.

4 East 89th Street, New York City 28, N. Y.

REFERENCES

1. Ackerman, Nathan: Psychoanalysis and Group Psychotherapy. *Group Psychotherapy,* 1950, 3:204-15.
2. Ackerman, Nathan: Social Role and Total Personality. *American J. of Orthopsychiatry,* Jan. 1951.
3. Hill, W. B.: Psychotherapeutic Intervention in Schizophrenia. *Univ. of Chicago Press,* 1955.
4. Wolf, Alexander: The Advanced and Terminal Phases in Group Psychotherapy. *Program in Various Existing Settings, Proc. of 2nd Ann. Inst. of Amer. Group Psychotherapy Assn.,* Jan. 1958, pp. 66-79, Ed. by M. M. Berger and M. E. Linden, pub. by Am. Group Psychotherapy Assn., 1958.

I'm 65, and I guess that puts me in with geriatrics. But if there were 15 months in every year, I'd be only 48.* That's the trouble with us. We number everything. Take women, for example. I think they deserve to have more than 12 years between the ages of 28 and 40.

James Thurber
Time Magazine, Aug. 15, 1960.

*Bad arithmetic. Thurber would be 52. (Corrected by Time's Editors.)

The Anatomy of Research for Psychotherapeutic Agents

KARL H. BEYER, JR., M.D., PH.D.

Robert Burton wrote an "Anatomy of Melancholy" that will be vaguely remembered as we recall our high school course in English literature. Quite apart from the use to which he put this excellent title, I sincerely wish that my title, "The Anatomy of Research for Psychotherapeutic Agents," really pertained to a description of the physiological basis for any of the clinical syndromes with which you deal. I wish that I could describe for you the anatomy or substance of melancholy, or despair, or of the many aberrations from that level of homeostasis we call normal behavior.

Though the emotions of man be as the shades of the rainbow, I would take satisfaction from the fact that there are only three primary colors from which the multitude of hues can be derived. Thus, with suitable adjustment of these three colors to make possible any hue, and with proper attention to saturation and intensity, we will have defined pretty well the parameters of color. The point I would make here is that with the direction of sufficient basic research to the seemingly complex problems of human behavior, an orderly exposition of basic physiologic factors will evolve, eventually.

I take a certain comfort from the belief that abnormal behavior is just like ours, only more so; for this, to some unsophisticated point of view, admits a basis for the advancement of therapy as we better understand the basic principles of neurophysiology and psychopharmacology.

In this connection, I would draw your attention to the seemingly simpler problem of dropsy, as it was viewed at one time and today. The congestion of the blood vessels and tissues and cavities was obvious, and so was the favorite therapy for much of the history of medicine—blood letting. Even the definition of factors responsible for the maintenance of blood pressure did not go far toward the advancement of therapy, but the advances in therapy as they happen to have been made gave a tremendous insight into the scope of the problem. Here, I refer to the introduction of digitalis to medicine and, more recently (historically), the advent of mercurial diuretics, for they accentuated the role of the heart and later the kidney in hemodynamics. Still more recently, as we have understood the significance of particularly adrenal effects on the cardiovascular renal system, and have been able to modulate the influence of specific renal tubular functions, there has been a surge in the advancement of therapy both of dropsy or heart failure and, for that matter, hypertension as well.

I would not belabor the development of cardiovascular physiology and therapy but to draw certain lessons from it which occasionally should be brought to mind. These can be summarized in a sentence: Although a tremendous effort need be put into the development of basic aspects of the physiology of behavior, nevertheless it should be possible to develop advances in therapy at the same time which would contribute to the basic understanding of behavior. In other words, we do not need to know all about a clinical entity in terms of its basic physiology in order to advance its management. The discovery and introduction of insulin preceded, but has contributed importantly to an understanding of the basic intermediary metabolic problems of diabetes. Antibiotics have contributed more to an understanding of bacterial physiology than has the latter to chemotherapy. The development

From: Merck Sharp & Dohme Research Laboratories, West Point, Pennsylvania.

Presented at the Seventh Annual Meeting of The Academy of Psychosomatic Medicine, Philadelphia, October 13, 1960.

of modern saluretic agents clinched the importance of salt retention in hypertension, and so on.

"The Anatomy of Research for Psychotherapeutic Agents" must be both gross and histomorphic, both generalized and minute in its detail, if it is to advance substantially in our day. A proper research program in this field should encompass both the most restrictive of questions for which there can be a yes or no answer, and questions so designed that they may elicit an answer that could not have been anticipated. We must work from within limits of knowledge, but somehow we must work in a manner that is not so restrictive.

"The Anatomy of Research for Psychotherapeutic Agents" must draw on all our resources together, rather than singly, if this field of therapy is to advance at its maximal rate. Thus, in our laboratory, the medicinal chemist, the biochemist, the general pharmacologist, the neurophysiologist, the experimental psychologist, the toxicologist, and the physician sit on the same Council for Mental Health. Their thoughts and research are made available to each other and each draws from this pool of information for perspective as he would detail or generalize his own effort. The chemist interested in structure-activity relationships, the enzymologist working at a subcellular level, and those interested in the neurocorrelates of behavior, all contribute to this advancement. In no previous research effort has such broad but concerted effort been brought to focus on a field of endeavor. As surely as chemotherapy deals with the modulation of biochemical reactions, not only the anatomy of melancholy or that of other psychosomatic problems, but their very manipulation will be ours to influence in measure and in time.

Psychosomatic medicine came into existence because of a need to bring together rapidly growing bodies of knowledge. It will have served its purpose when physicians stop thinking of diseases as having specific causes, when they really conceive of both health and disease as reactions of the human organism to a complex internal and external environment. This is the holistic point of view that is pervading modern medicine.

Stanley Cobb, M.D.
Foundations of Neuropsychiatry.

Treatment of Emotional Problems in Allergic Disorders: A Double-Blind Placebo-Controlled Study

JEROME MILLER, M.D.

It is well recognized that emotions may influence the course of allergic disorders. This concept is based on the premise that allergic individuals are sensitive to offending allergens and that this sensitivity is more readily manifested when the emotional threshold is lowered. In addition, repeated allergic attacks may themselves generate emotional distress, producing a vicious cycle that is characterized by anxiety, tension and apprehension.

Efforts to reduce the impact of stress and anxiety on patients have revolved around the use of sedatives and tranquilizers. Initially encouraging results with one of the most recent of these, thioridazine hydrochloride (Mellaril, Sandoz Pharmaceuticals) prompted a clinical evaluation to determine more precisely its usefulness in the management of the diverse symptoms found in the allergic patient with a low emotional threshold. An additional stimulus for study of this compound was derived from pharmacological study[1-3] and supported by early clinical reports[4-6] that it was virtually devoid of extrapyramidal stimulation, a side effect of the phenothiazines that appears sufficiently often to limit their usefulness in general practice. Corroboration of the greater toleration of thioridazine HCl has been reported by a number of other investigators.[7-10]

METHOD

At the time this study was initiated there were no available data regarding the use of thioridazine in allergic disorders. Accordingly, a pilot study was first undertaken to determine optimum dosage as a preliminary to the evaluation reported below. Tablets containing 10 mg. and 25 mg. thioridazine hydrochloride were employed in a total of 44 patients, 24 of whom also received a course of placebo as a measure of control. Results obtained with doses ranging from 20 to 25 mg., three times daily appeared to indicate that 10 mg. given three times daily provided the degree of efficacy and toleration in these patients most suited to the double - blind placebo - controlled study which was then initiated.

Design of Double-Blind Placebo-Controlled Study

Three separate forms of medication were tested, an active agent, #1 for comparative purposes; a placebo, #2, for control; and the test drug, #3, thioridazine hydrochloride. These were incorporated in pink gelatin capsules of the same size and shape, and were indistinguishable, one from the other, to the patients and to the investigator. The contents were as follows:

Capsule #1:	Bellergal (contains):	
	ergotamine tartrate	0.3 mg.
	Bellafoline	0.1 mg.
	phenobarbital	20.0 mg.
Capsule #2:	placebo	
Capsule #3:	Thioridazine HCl	10.0 mg.

Each of these formulations was tested in 57 patients (43 female, 14 male; age range, 24-67 years) for at least one month in one of the following sequences, 1-2-3 or 3-2-1. The use of placebo between that of the active agents was intentional to obviate carry-over drug effect. Only capsule #2 was identified for the investigator, while the identities of capsules #1 and #3 were withheld until the conclusion

From Skin and Cancer Hospital, Temple University School of Medicine, Union Health Center, A. F. of L. Medical Center, Philadelphia, Pa.

of the study. Each patient was seen every 10 to 14 days over a minimum period of three months, receiving on each visit only enough capsules to last until the next visit. The sequence was selected and rotated by an aide who was solely responsible for the distribution of supplies to the patients. The patient's subjective response was ascertained each time he or she returned, and this, plus the examiner's findings, formed a protocol for assessing the results in each individual. Improvement was measured on the basis of reduction in "somatic" complaints and relief of allergic symptoms, complemented by objective findings derived from examination of the nose, skin and chest. The data were collated by an individual not participating in the study.

Criteria for assessment were: excellent —complete relief of symptoms; good—relief judged to be of the order of 75-80%; fair—relief of the order of 50%; poor—no appreciable relief or intolerance to preparation.

RESULTS

Table I shows the type and variety of disorders treated and results obtained. Statistical analysis (Chi Square) of the data reveals that the results obtained with preparation #3, thioridazine hydrochloride, were very significantly better than those obtained with the two other preparations at well beyond the .001 level of confidence. Preparation #1 was superior to preparation #2 but not to a statistically significant degree.

While relief of nervous tension was the most prominent effect obtained with thioridazine hydrochloride, it was interesting to note concomitant improvement in the allergic state. This was most evident in the reduced complaints of wheezing and shortness of breath in the patients with bronchial asthma. Moderate to marked relief of itching of the eyes and nose was obtained in the cases of hay fever and was accompanied by a considerable reduction in sneezing and nasal discharge. Relief of itching in the cases of urticaria appeared to run counter with subsidence of lesions.

Drowsiness and dryness of the throat and nose were the only untoward side effects reported (Table I). In most instances, these occurred during the initial phases of treatment and usually disappeared in 5 to 7 days. The similar incidence for the three agents in the cases of hay fever appears to suggest that these patients may be more susceptible to emotional factors. On the other hand, it is interesting to note that only one patient with bronchial asthma complained of drowsiness while on placebo, in contrast to the drowsiness and dryness obtained with the active agents.

While the controlled study has much in its favor, it does not permit "tailoring of dosage" which we consider to be an integral part of individualized treatment. Accordingly, at the conclusion of this study, we re-tested some of the patients who had reported drowsiness with the thioridazine capsules. In their place, we now employed 10 mg. or 25 mg. tablets of thioridazine and took pains to "juggle" the dose and frequency of administration. We were surprised to note a number of instances where a patient was now able to tolerate larger amounts than were employed during the study and without the drowsiness previously reported. This "cross-over" study revealed that a regimen consisting of one 10 mg. tablet of Mellaril at 10 a.m., one 10 mg. tablet at 3 p.m., and one 25 mg. tablet after the evening meal provided the most consistently effective results, and was exceedingly well tolerated. The absence of any allergic reactions was noteworthy since some of the phenothiazines have been considerable to be allergenic themselves.

The response of a 12-year-old girl hospitalized for severe neurodermatitis with secondary infection and impetiginization of lesions was especially striking. Routine

TABLE I

Results of Double-Blind Placebo-Controlled Study

57 PATIENTS

	Therapeutic Response				Side Effects	
	Excellent	Good	Fair	Poor	Sleepy	Dryness of Mouth
Neurodermatitis						
1 Case						
Bellergal			1		1	1
Placebo				1	1	1
Mellaril	1				1	
Perennial Hay Fever						
22 Cases						
Bellergal		4	11	7	7	7
Placebo		5		17	6	5
Mellaril	3	14	3	2	6	5
Bronchial Asthma						
19 Cases						
Bellergal		4	6	9	5	9
Placebo		2	3	14	1	
Mellaril	3	7	3	6	3	9
Pruritus						
4 Cases						
Bellergal		2	2		1	1
Placebo			2	2		1
Mellaril		3		1	1	1
Urticaria						
6 Cases						
Bellergal	1	1	2	2	3	
Placebo		1		5	1	
Mellaril		5	1		1	
Angioneurotic Edema						
1 Case						
Bellergal			1			
Placebo		1				
Mellaril		1				
Plaintain Hay Fever						
1 Case						
Bellergal			1		1	
Placebo				1		
Mellaril			1			
Anxiety Neurosis						
2 Cases						
Bellergal		1	1			
Placebo		1	1			
Mellaril		2				1
Migraine						
1 Case						
Bellergal			1			
Placebo				1		
Mellaril		1				

measures affected sufficient improvement to permit discharge, but this was followed by a cycle of pruritus, scratching, excoriations and acute anxiety. Three days after the institution of Mellaril, there was a marked diminution in itching and scratching and a noticeable feeling of well-being. The lesions healed within the week.

The value of thioridazine in a dose of 10 mg. twice daily and 25 mg. at bedtime is well illustrated in a patient with asymptomatic bronchial asthma. The patient was depressed and the fear of losing her job had precipitated palpitations alternating with recurrent bouts of asthma. Within 48 hours, there was pronounced relief of tension and this was followed shortly by marked improvement in the asthma. Not all patients responded as dramatically, but the over-all reduction in anxiety and tension was quite consistent in most of the patients.

DISCUSSION

Increasing attention has been directed in recent years to the relationship between emotional factors and the allergic state. Worry and tension are considered as the trigger mechanisms for precipitating attacks in allergic individuals,[11] and more specifically, in urticaria,[12] intractable asthma,[13] hay fever[14,15] and atopic dermatitis.[16] While avoidance and elimination of sensitizing agents and specific anti-allergic therapy are prime requisites of treatment, it is obvious that alleviation of symptoms by palliative measures is essential for effective management of the allergic patient.

The results obtained in this study demonstrate that thioridazine hydrochloride is extremely effective in relieving the diverse emotional symptoms associated with various allergic disorders. Its usefulness was enhanced by the relatively few side-effects encountered in these patients.

This study also sought to explore the thesis that allergy and imbalance of the autonomic nervous system are inter-re-

lated.[17] Stimulation of autonomic effector organs by epinephrine and acetylcholine provides a pharmacologic basis for this viewpoint[12,18] and suggested the inclusion of an autonomic blocking agent in this evaluation as an active control. For this purpose, we chose an autonomic stabilizer (capsule #1) which has been described as beneficial in promoting mental rest in the treatment of allergic or vasomotor rhinitis.[19] This calmative effect was also observed in this series, but to a significantly lesser degree than that obtained with Mellaril.

SUMMARY AND CONCLUSIONS

This study has shown that the control of emotional imbalance obtained with thioridazine hydrochloride contributes to the successful management of the allergic patient. Thioridazine hydrochloride was found to be well-tolerated and markedly effective in relieving the nervous tension and anxiety associated with some allergic disorders, especially urticaria, perennial hay fever and bronchial asthma, and served as a useful adjunct to the treatment of these conditions.

BIBLIOGRAPHY

1. Taeschler, Von M., and Cerletti, A.: *Schweiz med. Wchnschr.*, 88:1216 (1958).
2. Swinyard, Ewart A., Wolf, Harold H., Fink, Gregory B., and Goodman, Louis S.: *J. Pharmacol. & Exper. Therap.*, 126: 312 (1959).
3. Haley, Thomas J., Flesher, A. M., Raymond, K., Komesu, N., and Williams, P.: *Toxicol. & Appl. Pharmacol.*, 1: 377 (1959).
4. Fleeson, W., et al.: *Univ. Minn. M. Bull.*, 29: 274 (1958).
5. Cohen, S.: *Am. J. Psychiat.*, 115: 358 (1958).
6. Kinross-Wright, J.: *J.A.M.A.*, 170: 1283 (1959).
7. Azima, H., Durost, H., and Arthurs, Dorothy, R.N.: *Canad. M.A.J.*, 81: 549 (1959).
8. Freed, S. C.: *Internat. Record of Med. & Gen. Pract. Clinics*, 172: 644 (1959).
9. Ostfeld, A. M.: A New Tranquilizer in General Practice. Scientific Exhibit American Academy of General Practice, San Francisco, April (1959).
10. Hollister, L. E., and MacDonald, B. F.: *California Med.*, 91: 274 (1959).
11. Sulzberger, M. B., and Zaidens, S. H.: *M. Clin. North America*, 32: 669 (1948).
12. Harris, M. C., and Shure, N.: *Practical Allergy.* Philadelphia: F. A. Davis & Co. (1957) p. 160.
13. Apley, J.: *Lancet*, p. 641, March (1959).
14. Rees, L.: *J. Psychosomatic Research* (London), 3: 234 (1959).
15. Koelsche, G. A., Peters, G. A., McBean, J. B., and Henderson, L. L.: *Proceedings of the Staff Meetings of the Mayo Clinic*, 34: 351 (1959).
16. Kierland, R. R., and Walsh, M. D.: *M. Clin. North America*, 34: 1009 (1950).
17. Kuntz, Albert: *The Autonomic Nervous System*, ed. 3, Philadelphia: Lea & Febiger (1945).
18. Rothlin, E., and Bircher, R.: *Fortschr. Allergielehre*, 3: 434 (1952).
19. Urbach, E., and Gottlieb, P.: *Allergy.* New York: Grune & Stratton (1943).

The time is past when we can get into a wrangle over whether a condition is psychogenic, physiogenic or chemogenic. . . . Any disease must be considered as a combination of all three.

Karl Menninger, M.D.
A Psychiatrist's World.

Psychophysiological Reactions of the Oral Mucosa

MELVIN LAND, M.A., D.D.S.

INTRODUCTION

In man, correlations between emotional behavior and body changes are abundant, but cause and effect relationship have been difficult to establish.[1]

It has been observed that apthous and herpetic-like eruptions of the oral mucosa may "develop without evident cause and in the absence of organic pathological conditions."[2] Such observations cause us to postulate a psychophysiological reaction. Dr. William B. Terhune has said: "There should be closer cooperation between pediatricians, internists, research scientists and psychiatrists in an effort to learn more of the nature of physiopsychic reactions . . . we must attempt to correlate the findings of organic medicine with those of psychodynamics. . . ."[3]

REPORT OF A CASE

History: 1952-1960. A 25-year-old secretary was first seen May 3, 1952; she presented the history of a development of recurrent groups of ulcers in her mouth. (Figures 1 and 2.) These aphthous and herpetic-like lesions were distributed throughout the oral mucous membranes and along the lateral aspect of the anterior two-thirds of the tongue. In Figure 1 at A we can note the ulcerated area involving the right buccal and inferior labial mucous membrane. This area also shows evidence of acute inflammation extending to the mid-line of the inferior lip. Figure 2 presents a view of the buccal mucosa opposite the maxillary molar teeth. Several ulcers can be observed at point B. The enamel hypoplasia with extensive incisal abrasion can also be noted at X in Figures 1 and 3. The onset of these ulcers occurred in September 1951, when she was in the process of obtaining a divorce. Since then there has been recurrent bouts. This first "case of ulcers" was described as mild. This patient was examined by her physician in December 1951, "He made all types of tests, which were negative." She reported having had "shots of vitamins B and C," also bismuth every third day intramuscularly. She also reported: "I had my mouth swabbed every other day, but they finally ran their course." The patient stated that she had had "diarrhea, but no vomiting; I had virus X, went on a diet and took paregoric, which helped the diarrhea."

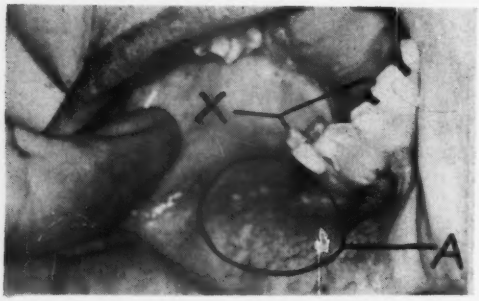


Fig. 1, 1952. Multiple ulcers involving the right mandibular buccal and inferior labial mucous membranes. Marked enamel hypoplasia with moderate abrasion of incisor teeth can be seen at X.

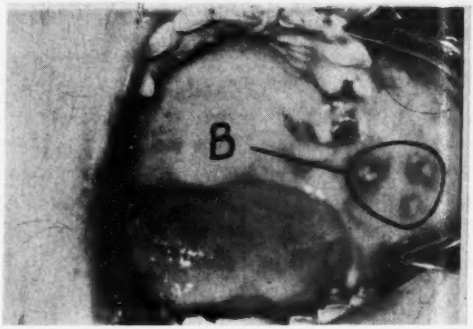


Fig. 2, 1952. Multiple ulcers involving maxillary left buccal mucous membrane.

A mild case of ulcers was reported to have occurred the last of January 1952. The same treatment was instituted. The

last of February and the first week of March 1952 the ulcers recurred and lasted about the same length of time (8 to 10 days). The patient reported: "I tried burning them off with silver nitrate, but they would come back, so I stopped this."

On one occasion the patient was hospitalized and repeatedly vaccinated with smallpox vaccine, with no lasting effect.

The patient noted she had three warts on each hand, which started about the same time as the blisters in her mouth. She referred to the warts as "the most ugly things I have ever seen."

The last week of April and the first week of May, 1952, they recurred. This bout was reported as a mild attack. The patient was next observed April 9, 1954, when she presented with a rather severe case of ulcers. At this time inter-oral photographs were taken (Figures 3 and 4). It can be noted from the photographs that this attack is more severe than the 1952 attack. It is also of interest that the lesions are almost exactly reversed with respect to their location. In 1952 the left maxillary buccal mucosa (Figure 2), and right mandibular buccal mucosa (Figure 1), were involved. In 1954 the right maxillary buccal mucosa (Figure 4), and the left mandibular buccal and labial mucosa (Figure 3), were involved.

April 11, 1954, the Thematic Apperception Test was administered to her.[4] The patient was seen on April 14, 19 and 26. During this time she was free from ulcers. The lesions recurred on June 4, 1954. After a 1½ hour visit the patient was dismissed and was not observed again until July 16, 1956, when she came in for observation and consultation. At this time there were multiple ulcerations which appeared to be healing; these were distributed bilaterally throughout the buccal mucosa and over lateral aspects of the tongue. This was judged as one of the most severe attacks.

From June 4, 1954 to November 1954 there were no ulcers reported. The patient became pregnant in November 1954. She reported: "I had been trying to get pregnant for 6 or 7 months. Three months after the baby was born I had a bad case of ulcers." This was October 1955. "We bought a home in February 1956 and I had only a mild case. Then in May I had a severe relapse. I base this on the fact that my brother was going with another girl," etc.

The patient was seen in March 1958, at which time she reported having had ulcers in December 1957, which continued to January 1958. "They were at their peak January 1, 1958. This was a severe bout." "I had something different this time; they were farther back, even in my throat; also my tongue and in my mouth and at the sides." She mentioned she had only single ulcers since the last attack. The patient stated that the only thing that was worrying her was a business situation between her husband and father. She also mentioned she was planning a child for April 1959. (The child was born June 1959); also she said she was always run down in December. "I am working under pressure; we have so much to do; I don't get much sleep and my system is always run down; I imagine that could have something to do with it."

In July 1958 she had another severe attack. "This was a bad case." As a result of this attack the patient decided she

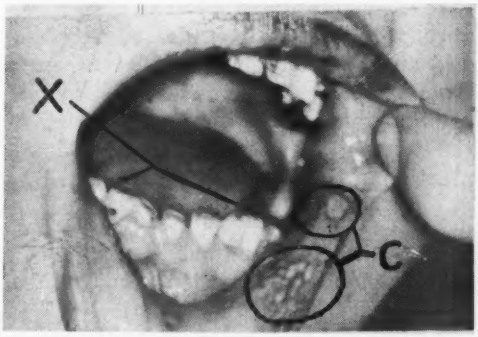


Fig. 3, 1954. Multiple herpetic-like ulcers involving mandibular left buccal and inferior labial mucous membranes.

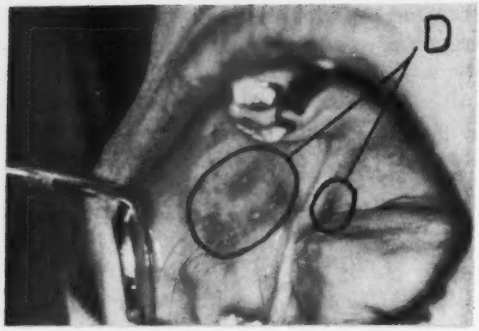


Fig. 4, 1954. Multiple ulcers involving maxillary right buccal mucous membranes and the right lingual pillars.

would give up smoking; she had noted that earlier, when she did not smoke she was free from ulcers. The result was there were no ulcers until she started a rather extensive restorative dental program. During the dental treatment, which lasted from February 1960 to June there were recurrent "bouts of ulcers." The patient noted on one occasion during the dental treatment that she became allergic to certain foods and large welts broke out around the shoulders. This she attributed to "peanuts or strawberries." Ten days after completion of the dental program she was free from ulcers.

The patient was seen in August 1960 and the oral examination revealed a remarkable change in the appearance of her teeth, as well as the oral mucosa (Figures 5 and 6). All teeth had been restored, with a definite improvement in appearance. She seemed well pleased with herself and was quite sure she was cured from her ulcers. There was one small ulcer that was in the process of healing on the tongue. The patient had made no mention of this during the interview.

Personal History: 1952

The third child and only daughter of a city employee, the patient recalled her early home life as being relatively pleasant. She did well in school, was popular, had a good time and dated frequently. She obtained a bachelor degree from college. She did have considerable difficulty in her first marriage, which occurred at age 22 to a man aged 24. She attributed her difficulty to his immaturity, temper tantrums and child-like behavior. She described herself as being a friendly person, extremely close to her friends. She is not high-tempered or sensitive, although she stated that she has been quite sensitive at times in the past. She is rather meticulous about the way she does things, and in her personal appearance. She stated she used to be sensitive about her teeth, but is not aware of it at the present.

The patient gave a history of some emotional difficulty when she was in college, characterized by attacks of anxiety, palpitations and some difficulty in breathing. She said that she had considerable menstrual difficulty at about that time (menorrhagia); associated with this was a considerable amount of depression. Her father, now aged 60, is described as an intelligent person, always rather meticulous, and who has had ulcers for years. She said, "He is pretty devoted to me and has told me at times I am his whole life." Her mother, age 57, is a jolly, good-natured person who has a tendency to worry about little things. The mother had a nervous breakdown when the patient's brother was killed during World War II. There are four siblings.

Physical Examination: 1952

Blood pressure 115/70. The pupils were rather large and reacted to light and accommodation. Her mouth revealed missing posterior teeth, both in the mandibular and maxillary arch, which had been replaced with a prosthesis. The anterior teeth showed evidence of moderately severe mottling of the enamel. The teeth were quite short with excessive spacing between contact area. Areas of the oral mucous membranes from the lips to the pillars of the fauces were involved with ulcers of various sizes. See Figures 1 and 2.

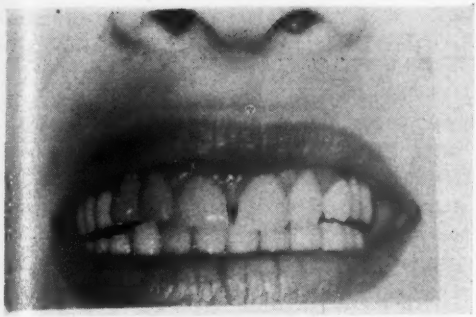


Fig. 5, 1960. After dental rehabilitation normal appearing oral mucous membranes.

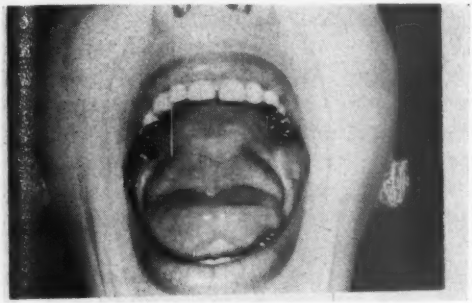


Fig. 6, 1960. Post-operative appearance of the dentition.

Psychiatric Evaluation: 1952

The patient, a neatly dressed, attractive young woman, who was tense during the entire interview, restless, somewhat overtalkative and had a rather artificial laugh, showed no evidence of delusional thinking nor of any psychotic behavior. She was well oriented in all spheres, of average or above average intelligence, showed good judgment and intellectually accepted the emotional aspects of her difficulty, although her emotional understanding of it was very limited. She presented many characteristics of an apparently outgoing and friendly individual who is very dependent and in need of close friendly relationships.

Diagnosis: 1952

The diagnosis of this patient was made by the psychiatrist after the initial interview. It was labeled as a psychosomatic disorder in an obsessive-compulsive personality type.

SUMMARY

A case of recurrent aphthous stomatitis with herpetic-like lesions is presented. The history, observation and findings support diagnosis of a psychophysiological reaction involving the oral mucosa in an obsessive-compulsive personality type.

2623 Abrams Rd., Dallas 14, Texas.

BIBLIOGRAPHY

1. Ingle, Dwight, J.: *Principles of Research in Biology and Medicine.* Philadelphia: J. B. Lippincott Co., 1958, pp. 70-71.
2. Cecil, Russell L., and Robert F. Loeb: *A Textbook of Medicine.* Philadelphia: W. B. Saunders Co., 1959, page 28.
3. Terhune, William B.: *Psychosomatics,* 1: (No. 3) 150, page 150.
4. Shneidman, Edwin S., Ph.D.: *Thematic Test Analysis.* New York: Grune & Stratton, 1951, pp. 31-39.

The Asthmatic Narcotic Addict

RICHARD D. CHESSICK, M.D., MORTON L. KURLAND, M.D., ROBERT M. HUSTED, M.D., and MURRAY A. DIAMOND, M.D.

In October and November, 1958, and as a check again in May, 1959, all the admissions to the U.S. Public Health Service Hospital for narcotic addicts at Lexington were screened for bronchial asthma by physical examination and medical history. This was done by a physician in the admissions unit, and when any indication on history or physical examination of bronchial asthma was found, the patient was carefully examined by a member of our team. It was determined that of 645 admissions in October and November, 1958, 6.0 per cent (39 patients) could be definitely diagnosed as having or having had bronchial asthma, and of 404 admissions in the month of May, 1959, checked by different physicians to eliminate possible bias in the diagnosis, 5.2 per cent (21 patients) had a similar diagnosis. These prevalence figures are considerably higher than the figures of Balyeat[1] who found an overall prevalence of 1.5-2.0 per cent of people in the United States "who suffer from (bronchial) asthma," although no information is given how this figure was determined or what criteria were employed.

In addition, it was found that the prevalence of bronchial asthma in patients staying over two months (about half the voluntary patients here sign out against medical advice within the first week) was as high as 12.5 per cent, and among those voluntarily staying, it was 14.0 per cent.

It was our clinical impression that the prevalence of asthma was highest among the white patients and among those in higher socio-economic circumstances, but this was very difficult to test statistically, since this type of patient tended to leave the hospital very quickly after admission, usually within a few days. We were able to study intensively only those patients staying for a period of two months or more. Such patients, whether they had asthma or not, were all consecutively screened with respect to age, sex, race, number of admissions, beneficiary status, frequency of exposure to asthma in the household, sibling order, occupation, education, and the occupation and education of their parents. Of the 232 patients studied in May, 1959, who stayed over two months, no significant difference was found on any of these variables between patients with or without asthma, except there was considerably more exposure to asthma in the household reported among patients with bronchial asthma—80 per cent had been exposed whereas only 10 per cent of patients without asthma reported people living in the household while they were children who had asthma.

All of the patients with asthma that could possibly be intensively studied, a total of 38, were interviewed by at least two psychiatrists. Psychological tests were given to 9 patients, and 6 patients received psychotherapy for a period of 6 months or more.

All but five of this group of 38 asthmatic narcotic addicts had the onset of their asthma in childhood ("extrinsic" asthma). Most of them suffered from frequent and severe attacks. The asthma attacks ceased by the early twenties in 9 of the patients, at least two years before they began taking narcotics.

About 80 per cent (22 patients) of the remaining 29 patients reported that their asthma attacks stopped completely or became much less frequent from the time they became physically dependent on opiates (usually heroin). Of the 29 patients, 6 had no further attacks once they were

From United States Public Health Service Hospital, Lexington, Kentucky.

"hooked." Four continued to have occasional attacks, which were relieved *only* by a shot of heroin. Twelve patients reported relief of attacks (that persisted after they were on opiates) from heroin and the usual medications (epinephrine, aminophylline), but with much quicker and efficacious relief from heroin.

Of the 7 remaining patients, 3 got more relief from the traditional medications, one felt they were about equally efficacious, and 3 got relief *only* from the traditional medications (see Table I).

TABLE I

Item	*No. Pts.*
A. Age at Onset of Asthma	
Childhood or early adolescence	33
Over 30	5
B. Cessation of Attacks	
Two years before addiction	9
From onset of physical dependence on opiates	6
Still present but less frequent after addiction	16
No change after addiction	5
Asthma began after addiction	2
C. Reported Response to Medication by Those Patients Still Having Attacks	
Only opiates relieve attacks	4
Opiates much better than traditional medication	12
Opiates the same as traditional medication	1
Traditional medication better than opiates	3
Relief *only* from traditional medication	3

It is difficult to explain physiologically the effect of opiates (usually heroin) in relieving asthma attacks, in the face of the many admonitions in the medical textbooks warning against the use of morphine in asthma, because of the consequent central respiratory depression and local constriction of the bronchioles.[2]

Generally, respiratory depression is a disadvantage to the use of opiates. However, in some illnesses morphine is used to relieve dyspnea, such as in pulmonary edema or cardiac asthma. In conditions where the alveolar carbon dioxide concentration is already increased, such as pulmonary emphysema or severe bronchial asthma, fatal carbon dioxide intoxication could result from use of morphine. It is generally agreed that the respiratory quotient is lowered, and the respiratory response to inhaled carbon dioxide is decreased by morphine. Relatively little investigation has been done on the clinical responses to heroin. Generally, the physiological responses are very similar to those of morphine,[12] but heroin is more potent.[11,12]

Several studies have shown that meperidine can give dramatic relief from acute asthmatic attacks.[8,21] This might be explained by the observation that meperidine is an anticholinergic and antihistaminic drug. Morphine, on the other hand, probably has no antihistaminic action and is cholinergic.[16]

If we postulate that "extrinsic" asthma is stimulated by histamine and "intrinsic" asthma by acetylcholine, then morphine should have a more adverse effect on patients with "intrinsic" asthma. In our series of 38 cases, only 5 could be classified as "intrinsic" asthma. Four out of these 5 cases responded to heroin dramatically in reducing the frequency of attacks and stopping attacks in process, according to their reports. One patient said heroin had no effect on the attacks.

Therapeutic doses of morphine cause the release of significant amounts of epinephrine into the blood stream.[14] Possibly, this release of epinephrine may relieve symptoms of bronchial asthma.

As difficult as it is to account physiologically for the relief of acute asthmatic attacks by the use of heroin, it is even more difficult to explain the decrease or cessation of attacks altogether when the patients become addicted to heroin.

The relief of asthma attacks by opiates in narcotic addicts could be more easily explained psychologically on the basis of our psychiatric studies of these patients. From our psychiatric and psychological

studies we were convinced that the major psychological mechanism involved in the symptom formation of the patients both in asthma attacks and drug addiction was that of introjection. As previously described in the literature,[7,20,24] the asthma attacks were often precipitated by some conflict involving the potential or actual loss of "mother-love" or a mother figure. The reaction to this we found involved florid phantasies of introjection of the lost object, asthma attacks, and in a few cases, psychosis. For example, one patient developed his first asthma attack as a child on a picnic and had to be returned home to his mother, whereupon the attack ceased. He repeatedly dreamed of trying to climb a mountain and never being able to reach the top, often waking with an attack of asthma. His asthma, very severe, came and went with the vacations and holidays of the therapist; when the therapist was transferred he developed a psychosis.

Another patient described the use of drugs as giving her a feeling of satisfaction and fullness in the stomach. She compared this feeling to the sensation after eating a fine meal. She volunteered that when she stops using drugs she eats voraciously and cannot eat enough food to satisfy her. During psychotherapy she developed a severe anxiety reaction accompanied by wheezing and the feeling of suffocation following a quarrel with her sister, during which the sister chided her about staying in the hospital rather than looking after her children. That night she had three nightmares, all involving the bloody cutting up of this sister. This was followed by a nightmare in which her mother was hitting her around the mouth and nose, and her face became bruised and swollen. That morning she decided to absolutely stop smoking, although she was a heavy smoker. Two weeks later she made up with her sister and then began smoking again; the agitation and anxiety disappeared.

The more prolonged and intensive the therapy, the more florid the phantasies of introjection, and the more intricate a weaving appeared of the symptoms of depression, asthma attack, and narcotic craving. One patient reacted to the therapist's vacation with an asthma attack and a dream in which a quack doctor injected a clear substance into his ear. In a following dream he flew into a rage at a man who was taking his cigarettes, and this was followed by a scene where he was cut to pieces and placed in an iron lung, where he slowly smothered. He awoke gasping for breath. Later he expressed the wish to put the therapist in "a glass house." This led associatively to his desire for "the lady in the glass jacket" (heroin), and the appearance of withdrawal symptoms (lacrimation, salivation, yawning, itching, perspiration), and finally shortness of breath.

The case of an asthmatic narcotic addict described by Winkelstein showed similar preoccupations.[23]

It has been demonstrated by Fort[6] and Chessick[3] that injection of drugs may have the psychological meaning of introjection of the ambivalently loved lost mother-figure, accompanied by a "pharmacogenic orgasm."[18] This sensation, in addition to being produced by physiological dampening of primary drives, contains the phantasy of tucking mother's breast safely inside, or fusion with the mother. It would follow that the injection of drugs would relieve asthma attacks by relief of longing for the mother through this phantasy and the "pharmacogenic orgasm." Perhaps it is analogous to the crying hungry baby having a nipple thrust in its mouth and being satiated with milk.

The psychiatric literature contains similar descriptions of the basic personalities of patients with manic-depressive psychosis, narcotic addiction, and bronchial asthma. The pregenital nature of conflicts in these patients is stressed, and also the extensive use of introjection (e.g. re-

spiratory incorporation) in their phantasy life.

Rado[19] pointed out the similarity of narcotic addiction to manic-depressive psychosis. In both illnesses the course of the patient's life is marked by periods of depression interrupted by periods of elation. He described the "tense depression" of the narcotic addict interrupted by the "pharmacogenic orgasm" introduced through the use of drugs by the patient. Lewin[13] has compared the state of "being on the nod" or "pharmacogenic stupor" to manic elation. The marked mood swings of both manic-depressive patients in the premorbid state and in addicts withdrawn from drugs had often been observed.

Object relations are described similarly in narcotic addicts and patients of the manic-depressive type. Both tend to see people merely as impersonal objects to be manipulated for their own ends.[3,4] They tend to be extremely ambivalent towards people they are dependent on. Precipitation of manic-depressive states or narcotic addiction states has been related to the loss of such objects of dependency gratification.

Similarly, bronchial asthma has often been connected with manic-depressive psychosis in the literature, with the *additional finding* that bronchial asthma seemed to disappear during manic-depressive psychotic episodes and reappear in the non-psychotic state. Dunbar[5] quotes Fromm-Reichmann's conclusion that manic-depressive swings are of special frequency in asthmatics, and Hansen's statement that, "certain asthmatic individuals show to a more or less marked degree, symptoms of manic-depressive disease, and asthma attacks predominate in attacks of depression." Fenichel discovered a "definite relationship" between manic-depressive psychosis and asthma, and Saxl described the patient who had asthma which disappeared during acute psychotic attacks of manic-depressive psychosis and reappeared when the psychosis subsided.[5] Oberndorf also describes such a case.[17] Kerman quotes from Brown and Goitein's study[9] which reported that the asthmatic subject is "of a cyclothymic disposition, associated with paranoid features, repressed hostility, and self-punishment motives." He reports two cases of patients with bronchial asthma and manic-depressive disease, where the asthma disappeared during the depressive episodes. Electric shock therapy improved the depression, whereupon the asthma returned. One of his cases, it should be noted, was a severe chronic alcoholic.

Object relations and precipitations of attacks as described above in narcotic addicts and manic depressive psychotics, are similarly described in asthmatics.[10,15] Many authors have reviewed the literature extensively and they support the theory that asthmatic attacks frequently develop as a reaction to separation from the mother or mothering one, as first hypothesized by Weiss.[22] They also indicate that emotional conflicts of analogous nature, such as threats to dependent relationships in general and the need to suppress an emotional longing for such relationships, are intimately associated with the onset and continuation of bronchial asthma. Oberndorf[17] has pointed out the similarity of the respiratory tract and the alimentary tract in introjection phantasies. Knapp and Nemez[10] mention the drug hoarding and "addictive propensity" of asthmatics.

If this similarity of personalities, object relations, precipitating factors in attacks, and the extensive use of introjection in the phantasy life is correct, then we should expect to find a higher prevalence of bronchial asthma in narcotic addicts. Our data confirm this expectation. The shifting between these three states would also be understandable; thus, the narcotic addict is often depressed when he is not addicted, the asthmatic is often depressed when he has no asthma, and loses the

asthma and depression when he becomes addicted.

We feel this is a preliminary study. Further directions that need investigation are a) an attempt to verify the subjective reports of narcotic addicts about the effect of drugs and drug addiction on their asthma, b) careful sociological study of patients with narcotic addiction and asthma who leave soon after they arrive in our hospital, to verify our impression of their higher socioeconomic circumstances, and c) further physiological studies of the effect of opiates on asthma.

(R.D.C.) 25 E. Washington St., Chicago 2, Ill.

BIBLIOGRAPHY

1. Balayeat, R.: *Hay Fever and Asthma.* Davis and Co., Phila. 1928.
2. Cecil, R., and Loeb, R.: *Textbook of Medicine.* Saunders, Phila,, Pa., 1951, 8th Ed., pp. 466.
3. Chessick, R.: The "Pharmacogenic Orgasm" in the Drug Addict." *A.M.A. Arch. Psychiat.,* in press.
4. Cohen, M. B.: *Psychiatry,* 17:103-137, 1954.
5. Dunbar, F.: *Emotions and Bodily Changes.* Columbia Univ. Press, N. Y., 1935.
6. Fort, J.: *Psychiatry,* 17:251-259, 1954.
7. French, T., and Alexander, F.: *Psychosomatic Medicine.* Monograph No. 2, 1941.
8. Herschfus, J. A., and Segal, M.: *Annals Int. Med.,* 40:506-515, 1954.
9. Kerman, E.: *Psychosom. Med.,* 8:53-57, 1946.
10. Knapp, P., and Nemetz, S.: *Psychosom. Med.,* 19:466-485, 1957.
11. Krantz, J., and Carr, C.: *Pharmacologic Principles of Medical Practice.* Williams and Wilkins Co., Baltimore, 1951.
12. Krueger, H., Eddy, N., and Sumevalt, M.: *USPHS Supplement No. 165,* 1941.
13. Lewin, B.: *The Psychoanalysis of Elation.* Norton, N. Y., 1950.
14. Light, A., et al.: *Opium Addiction.* A.M.A., 1929.
15. Marty, P.: *Int. J. Psychoanal.,* 39:98-103, 1958.
16. Mitchell, H., and DeJong, J.: *J. Allergy.* 25: 302-305, 1954.
17. Oberndorf, C. P.: *N. Y. State J. Med.,* 35:41-48, 1935.
18. Rado, S.: *Int. J. Phychoanal.,* 7:396-413, 1926.
19. Rado, S.: *Psychoanalyt. Quart.,* 2:1-23. 1933.
20. Treuting, T., and Ripley, H.: *J. Nerv. and Ment. Dis.,* 108:380, 1948.
21. Weinberg, S., and Sensiba, S.: *Dis. of Chest,* 30:580-582, 1956.
22. Weiss, E.: *Int. Ztschr. Psychoanalyse,* 8:440, 1922.
23. Winkelstein, C.: *J. Hillside Hosp.,* 5:78-90, 1956.
24. Wittkower, E.: *Recent Developments in Psychosomatic Medicine.* Lippincott, N. Y., 1955.

Two opinions Freud held all his life. One was that there was no evidence of psychical processes occurring apart from physiological ones: that no mind could exist apart from a brain. . . . The other was that physical processes must precede psychical ones: information reaching the mind, whether from the outer world through the sense organs, or from the body through the chemical stimuli it provides, must begin as a physical excitation.

"Life and Works of Sigmund Freud" by Ernest Jones, M.D.

Notes and Comments

The 1961 Academy Meeting

The Eighth Annual Meeting of the Academy of Psychosomatic Medicine will be held in Baltimore, Md., October 12 to 14, 1961. Dr. George Sutherland is Chairman of the Program Committee and Dr. Frank J. Ayd, Jr., is Co-Chairman. Preliminary information released to the Editor indicates that this meeting will surpass all previous ones. Details will be published in each successive issue as they become confirmed. At this point it can be mentioned that one feature will be an old-fashioned "Maryland Oyster Roast." Members will receive a free ticket to this affair.

Academy News Notes

DR. TITUS H. HARRIS of Galveston, Texas, was recently honored when the Titus Harris Society was formed by his former students. Dr. Harris has been head of the Department of Neurology and Psychiatry at the University of Texas Medical Branch since 1926 and was the first, and to date, only editor-in-chief of *Diseases of the Nervous System*.

DR. MAX KOENIGSBERG of Charleston, West Virginia, recently visited Dr. Fritz Dreyfuss, Assistant Professor of Medicine at the Hadassah-Hebrew University School of Medicine in Israel, and reports that plans are being made to form a regional chapter of the Academy of Psychosomatic Medicine in Israel.

DR. N. L. PETERSON of Beverly Hills, Massachusetts, recently spoke before the Maine Group Psychotherapy Association on his experiences in group psychotherapy. He has inaugurated courses in "Religion and Psychology" which will be given in Norwood, Mass.

DR. JORDAN M. SCHER, of Chicago, Illinois, participated in a Conference on Existential Psychiatry in New York City on December 11, 1960. This was planned by the American Ontoanalytic Association of which Dr. Scher is Secretary.

Items and Reports of Interest

Arrangements have been made for the first Trans-international Psychosomatic Seminars (TIPS) to sail on the *S.S. President Adams* of the American President Lines, leaving New York on Friday, September 28, 1962. A teaching seminar will be planned for every port visited, and ample time will be allowed for sightseeing. Reservations must be made well in advance. This is a non-profit organization offering teaching seminars gratis around the world, and if sufficient qualified persons volunteer their services, further TIPS will be organized. The itinerary planned includes: New York; Panama Canal; Los Angeles; San Francisco; Yokohama and Kobe, Japan; Okinawa, Ryuku; Keelung, Taiwan; Hong Kong, Saigon, Vietnam; Singapore, S. S.; Swettenhanm and Penang, Malaya; Colombo, Ceylon; Cochin and Bombay, India; Karachi, Pakistan; Suez and Port Said, Egypt; Naples, Italy; Barcelona, Spain; Marseilles, France; and Genoa and Leghorn, Italy. Contact Dr. James L. McCartney, 223 Stewart Ave., Garden City, N. Y.

The advancement of neuropsychopharmacology was the theme of a conference held in New York City on November 12th and 13th, 1960. Clinical psychiatrists, educators, researchers in basic sciences as well as clinical investigators participated. Evaluations of present day methods of training investigators and testing drugs, and the difficulties in obtaining swift dissemination of accurate information to the medical profession were critically discussed. Among the recommendations was that a new society be formed with the purpose of advancing knowledge in this important area of psychiatric research. An organizing committee to implement the recommendations was formed. The next meeting of the committee is scheduled for February 1961 and it is probable that the new society will be organized in time for the May meeting of the American Psychiatric Association. Participants in the conference included: Drs. Frank J. Ayd, Jr., Bernard Brodie, Eugene M. Caffey, Jr., Jonathan O. Cole, Erminio Costa, Wilfred Dorfman, Edwin Dunlop, Paul Feldman, James T. Ferguson, Douglas Goldman, Paul H. Hoch, Ebbe Curtis Hoff, Abram Hoffer, Jorge A. Lazerte, Heinz E. Lehman, Nolan D. C. Lewis, Sidney Malitz, Theodore Rothman, Anthony A. Sainz, Arnold B. Scheibel, and Joseph M. Tobin. The Academy was well represented by Drs. Ayd, Dorfman, Dunlop and Rothman.

Medical Tribune for December 5, 1960, mentioned "The Myelogram Sign" as an important clue in the possible diagnosis of carcinoma of the pancreas. According to E. D. Palmer in *Clinical Gastroenterology*, this sign is merely the fact that the patient has acquired many roentgenograms, among them a negative myelogram. Related to the fact that this illness often produces pain that radiates to the back, it is not surprising that the patient may eventually need this procedure. The importance of this negative finding is readily apparent when one realizes that carcinoma of the pancreas is one of the fatal "neuroses," due to the failure of diagnosis.

According to Dr. Lawrence Z. Freedman of the Yale University School of Medicine, the so-called "truth" drugs often release untruthful statements. Narcoanalysis will usually stimulate the non-communicative patient to talk without inhibition, but apparently the truth does not always come out.

Members of the department of psychiatry of the Jefferson Medical College in Philadelphia, Pa., conducted a survey of G.P.'s in the Reading, Pennsylvania area and found that 78 per cent felt a need for supplementary psychiatric training. The doctors who received their medical degrees within the past 20 years found a higher percentage of emotional problems in their patients and attempted treatment themselves, while the older doctors used psychiatric consultation to a greater extent.

Security in old age depends more on human relationships than on the mechanical provision of human needs, according to Dr. T. N. Rudd, consulting physician at Southampton General Hospital, England, whose report appeared in the June 1960 issue of the *Journal of the American Geriatric Society.*

Postgraduate Courses and Meetings

Psychiatry for the Internist: University of Colorado Medical Center, Denver, Colo. C. Wesley Eisele, M.D., and Herbert S. Gaskill, M.D., Co-Directors, June 19-23, 1961.

Psychiatry for the Practitioner: Dalhousie University School of Medicine, Halifax, N. S. Prof. R. O. Jones and Staff.

Adolescent Medicine: Tulane University School of Medicine, New Orleans, La., 1430 Tulane Ave., New Orleans, 12.

Psychiatry: University of Michigan Medical School, Ann Arbor, Mich. Dr. John M. Sheldon, Rm. 1610, University Hospital.

The Lindauer Psychotherapy Weeks will take place in Lindau, Germany, from May 1 to 13, 1961. This is a postgraduate course in psychotherapy for the general practitioner. The *Vienna Congress on Psychotherapy* will take place August 21 to 26, 1961. For full information please contact Mr. Jacques Brachfeld, Prisco Bureau, 1 DeKalb Ave., Brooklyn, N. Y.

The Third World Congress of Psychiatry, McGill University, 1025 Pine Ave. West, Montreal 2, Canada, June 4-10, 1961.

AWARD CONTEST ANNOUNCEMENT

In the past, the Academy of Psychosomatic Medicine has offered a prize medal for the most stimulating and original paper in the field of psychosomatic medicine. This year the prize will be given to the senior author of the best paper submitted for publication in *Psychosomatics* in the September-October 1960 through May-June 1961 issues. Excluded from the competition will be officers and members of the executive council of the Academy as well as members of the editorial board of *Psychosomatics.* The full editorial board will be published in the January-February issue. Announcement of the winner will be made at the Baltimore meeting of the Academy of Psychosomatic Medicine.

Robert N. Rutherford, M.D.
Chairman, Awards Committee

InDoc(Spock)trination

An attempt to mock Spock
would undoubtedly shock
Those poor doting mothers,
to whom he's the cock
Of the walk, and their talk
about babies,—they'd balk
Like a group of sad frightened
and panicky rabbits,
If I should disturb
inDoc(Spock)trinated habits,
Or dare to cast doubt
on this new Aristotle,
This diaper dictator,
this boss of the bottle,
Whose wisdom like Solomon's,
logic like Plato's,
States why, when and where
junior gets mashed potatoes.

On his book's every page
may be found some new thesis,
Like Spock's own firm grasp
of what gives enuresis.
The problems of childhood
are met and defeated,
All ills catalogued,
given names and then treated.
But readers, confused,
may get awful neuroses,
To find they need doctors
to make diagnoses.
Frustrated, they're subject
to fits and conniptions,
Because Spock cannot teach them
to master prescriptions.

Besides Freud or Spock,
despite gobble-de-gook,
To raise (or make) kids,
they need more than a book.

Sam Silber, M.D.

Abstracted from the Medical Press

FACIAL PAIN. Arnold P. Friedman, M.D., Charles A. Carton, M.D., Trans. Amer. Acad. Ophth. and Otolaryn., 64:713-719, Sept.-Oct. 1960.

The differential diagnosis between typical and atypical facial neuralgia is made. In typical neuralgias pain is limited to the field of one of the cranial nerves whereas an atypical neuralgia does not follow the nerve distribution. The pain of typical neuralgia is paroxysmal, sharp, and localized whereas that of atypical neuralgia is diffuse, deep-seated, poorly localized, and described as pulling, gripping, etc. In typical neuralgia the pain lasts for seconds to minutes while in atypical neuralgia it lasts for hours or days. There are no autonomic nervous system signs in typical neuralgia while in atypical neuralgia there is lacrimation, flushing, nasal congestion, etc. Typical neuralgias are precipitated by external stimuli; the atypical forms are not. There are trigger zones in typical neuralgia but none in the atypical form. Typical neuralgias effect the older age group while the atypical type tends to effect mainly the younger age group. Vasoconstrictors do not help typical neuralgias but frequently give relief to atypical neuralgias. Typical neuralgias are relieved by surgical or chemical interruption of the cranial nerves whereas the atypical neuralgias are not. Neurotic traits are not prominent in typical neuralgias but are prominent in the atypical form. Whatever the initiating factor, pain in atypical neuralgias results from periodic attacks of local dilatation of extra-cranial vessels in areas mainly supplied by branches of the external carotid arteries, particularly the external maxillary. In most patients with complaints of atypical neuralgia, psychotherapy is the most important single method of treatment. In any of these patients, facial pain is only one of the many manifestations of a marked personality disturbance. Such therapy in many patients is within the realm of the general practitioner, but in other instances, more formalized psychotherapy is necessary. Symptomatic relief in atypical neuralgias may be obtained with ergotamine preparations. Suppositories prove to be more effective than oral administration and are more rapid in action.

T. F. Schlaegel, Jr., M.D.
Indianapolis, Indiana

PSYCHOLOGICAL MEANING OF DISULFIRAM (ANTABUSE) THERAPY. J. N. Bicknell, and R. A. Moore, A.M.A. Arch. Gen'l Psychiat., 2: 661-668, June 1960.

This is a report of one case history of antabuse induced psychosis which emphasizes the need for studying the meaning of antabuse to each patient. The authors mention a number of previous studies of the use of antabuse; however, they feel this study is unusual in that it was possible to intensively study this patient prior to, during, and after the use of the drug and believe it may be applicable to the understanding of the meaning of antabuse to other alcoholics.

A twenty-four year old patient with a passive aggressive personality disorder began to develop a psychotic episode three days after inception of antabuse therapy which cleared eight days after antabuse was discontinued. During the psychotic episode the patient revealed much of the previous unconscious meaning to him of taking the drug. Antabuse acted as a parental prohibition against drinking.

Kenneth W. Teich, M.D.
Duluth, Minnesota

THE ROLE OF HYPNOSIS IN THE TREATMENT OF INFERTILITY. L. Wollman, Brit. J. Med. Hypnotism, Vol. 11, No. 3, Spring 1960.

A long historical introduction with references culled from British, French and Russian sources is followed by a few case histories from the author's private practice.

Misconceptions about hypnosis are enumerated; and the "ideal" hypnotic subject is described.

Infertility problems of tubo-spasm, dyspareunia, ejaculation praecox, anxiety, one-child infertility, anovulatory cycles, pseudocyesis, and habitual abortion are discussed.

It is emphasized that hypnosis is an aid in therapy. It is not a new modality, having been used for centuries. A plea for a more extensive utilization of hypnosis in medical practice is made.

Author's Abstract.

COMPARISON OF A TRANQUILIZER AND A PSYCHIC ENERGIZER. Stanley J. Geller, M.D., J.A.M.A., 174:481-484, Oct. 1, 1960.

There has been a reported increase in juvenile delinquency, and much is written about "behavioral disorders." Such children pose serious problems to themselves, their families, and society, and in the past, the results of the purely psychotherapeutic approach have been somewhat discouraging. The advent of the newer psychotropic drugs has brought an increased measure of hope to the situation, although long lasting benefit can only be derived from psychotherapy. Geller in this paper brings out his results in seventy-five hyperactive, poorly integrated children who were divided into groups of twenty-

five for the comparative study of the effect of two drugs on their behavior. One group received deanol, a psychic energizer. The second received trimeglamide, a sedative, and the third group, a placebo. Deanol was found useful in improving the child's skills and performance, and trimeglamide in alleviating manifestations of tension. This study appears to have been well controlled and documented. Further work along this line is definitely indicated.

James L. McCartney, M.D.
Garden City, N. Y.

THE ANATOMY OF ANXIETY. H. S. Burr, Ph.D., Conn. Medicine, 24:1, Jan. 1960.

In the struggle of life, two environmental elements must be dealt with. The first element is comprised of the physical stimuli from the internal and external environment. Ideas constitute the second element and they assume major importance in man's adjustment to life. In the present state of knowledge, it appears that two different sets of nerve cells deal with each type of stimulus. Neurones in the basal ganglia are concerned with adjustment to the physical environment, the patterns of adjustment are inherited and primitive. One part of the basal ganglia, the thalamus, serves as a sensory center in which stimuli are integrated. The integrations must be converted into motor activity to maintain adjustment; this function is lodged in the second part, the caudate and lenticular nuclei.

Adjustment to ideas occurs in the cortex. The cortical neurones develop, both from an evolutionary and embryological standpoint from cells which wander out from the basal ganglia. In this wandering process, intercommunicating pathways between the basal ganglia and cortex are established. Because of the vast numbers of cortical neurones, extraordinary capacities for discrimination are added to the nervous system. The qualitative aspect of the cortex is the "mind" of man.

Although the mechanism is not understood, words as symbols for ideas become "locked" in the nervous system and activate other neurones. Since each person's experiences are unique, the individuality of man results.

The basal ganglia mediate primitive, automatic behavior; the cortex mediates rational, discriminative behavior. Anxiety occurs when these two controls are in conflict. Dominance of one type of control over the other is seen in certain types of behavior. If part of the frontal cortex is removed, the individual reverts to an "animal" type of behavior. Thus the cortex provides regulation of the more primitive reactions to environmental stimuli.

From this background, Dr. Burr, who is Emeritus Professor of Anatomy at Yale Medical School, goes on to discuss the implications of this material on educational philosophy and epistemology. His conclusions and the questions he raises in this section do not lend themselves to abstraction. The original article is provocative and well worth reading in its entirety.

F. W. Goodrich, Jr., M.D.
New London, Conn.

A STUDY OR PATIENTS ADMITTED TO A PSYCHIATRIC HOSPITAL AFTER PELVIC OPERATIONS. M. C. Hollander, Am. J. Obst. & Gynec., 79:498-503, March 1960.

In nine of 203 women admitted to Syracuse Psychiatric Hospital in 1958, pelvic surgery appeared to be the precipitating factor for the psychiatric disorder. This was in contrast to the five women admitted following operations of all other kinds. The most common clinical picture was one of an agitated depression.

There was a remarkable consistency in the patients' belief that the removal of the uterus and ovaries meant the end of all sexual life, at least in a feeling way, and that the inability to have children, whether these children were desired or not, profoundly affected the feeling of womanliness which is so crucial to the self image. These factors would most likely lead to profound psychiatric disorders in those patients who have been the least secure in this respect and who are unable to mobilize adequate defenses to combat feelings of "uselessness" and of being an "incomplete woman."

Although self-image and defensive efforts are basic, other factors are undoubtedly of contributory influence in determining the reaction to gynecological operations. These include the preparation of the patient for the operation, the attitude of the surgeon and other hospital personnel, and the current life situation of the patient, especially in terms of her relationship with her husband and children.

Kenneth W. Teich, M.D.
Duluth, Minnesota

THE SUBJECTIVE ELEMENT IN PERCEPTION. A. F. M. Brierley, The Sight-Saving Review, 29: 141-143, 1959.

This delightful article highlights how we tend to select and interpret sensory data in the light of our interests and general attitudes. It begins by including two "of's" in a sentence without the reader being cognizant of it. The author reviews the work of Bruner and Goodman who showed that sizes of coins are estimated by children to be larger than they actually are. Further, the greater the value of the coin, the greater

is the observed deviation of apparent from real size. Zangwill determined some of the influences of verbal suggestion upon perception by using an ill-defined ink blot with the information that it was intended to represent an animal and later using the same ink blot with the interpretation that it had a resemblance to a mountain range. The subjects all saw an animal in the first instance and most of them a mountain range in the second. Zangwill also studied the meaning given to non-sense syllables "sael" and "wharl." If it was previously suggested to the subject that he would perceive names of animals, he perceived them as "seal" and "whale." If he was led to expect something to do with boats, he saw them as "sail" and "wharf."

T. F. Schlaegel, Jr., M.D.
Indianapolis, Indiana

SUSCEPTIBILITY AND IMMUNITY TO COMMON UPPER RESPIRATORY VIRAL INFECTIONS—THE COMMON COLD. George Gee Jackson, M.D., et al. Annals of Internal Med., 53:719-737, October 1960.

Students were administered nasal drops containing either virus grown in tissue culture, nasal secretions from typical common cold cases, or a control salt solution. Subjects were not informed as to the nature of the challenge solutions instilled.

Of these, a small group were resistant both to natural and experimental infections. Neither total body chilling nor frigid conditions induced spontaneous infections or increased susceptibility to experimental infection. This is, of course, in sharp contrast with common superstition concerning the etiology of colds. Sleep deprivation and fatigue increased infectivity insignificantly. There was a slight difference in the susceptibility of females according to phases of the menstrual cycle.

Representative samples of volunteers were studied to determine possible psychologic factors which might be related to symptom reporting under experimental conditions. Projective techniques suggest that individuals who are prone to manifesting or reporting symptoms under experimental conditions are significantly different psychologically from those who report no symptoms after challenge. These differences seem to do with the individual's self-concept, degree of freedom from emotional stress, need for close interpersonal relationships, level of optimism or pessimism, concerning one's future, and attitudes toward illness in general. Cold symptoms were less likely to develop in individuals who did not believe they would experience the illness; who felt that emotional status did not influence physical status, and who reported no feeling of concern or worry about any extrinsic factors operative in their lives at the time of the experimental challenge. Individuals undergoing a particular emotional stress at the time of the experiment, and who were unable to envision some satisfactory resolution, were prone to report symptoms to a greater extent than the stress-free group.

Highly significant is a small group of subjects who developed cold-like symptoms from the instillation of a non-infectious salt solution, but who showed no greater susceptibility to actual infectious material than did other volunteers.

Sanford M. Lewis, M.D.
Newark, New Jersey

PSYCHIATRIC AND PSYCHOLOGICAL ASPECTS OF MYXEDEMA Carl P. Malmquist, M.D., and James C. Kincannon, B.S., Dis. Nerv. Syst., 21: 529-532, September 1960.

This paper reviews a case of myxedematous psychosis, in which there was a slow disappearance of the secondary functional signs of mental illness on the administration of thyroid medication. Psychological testing indicated some residual chronic signs of brain damage, presumably due to the long standing metabolic disorder from which the patient had suffered. The author discusses the possibility of such chronic changes, which are not usually detected, occurring in hypothyroid patients.

James L. McCartney, M.D.
Garden City, N. Y.

A CASE OF CAT PHOBIA. H. L. Freeman and D. C. Kenrick, Brit. Med J., 5197:497-502, Aug. 19, 1960.

The patient was a married woman, aged 37, admitted to Dayholme, Bethlehem Royal Hospital, because of a cat phobia, which started at age 4, when her father drowned a kitten in front of her. At age 14 her parents put a fur inside her bed, she became hysterical on finding it.

The successful remission of symptoms connected with cat phobia was effected by a technique derived from experimental psychology. The therapeutic technique — reciprocal inhibition (Wolpe, 1958) was originally introduced by Sherrington, and refers to situations in which the elicitation of one response causes a reduction in the strength of another, simultaneous response. When stimuli producing incompatible responses are present, the response that is stronger will cause the reciprocal inhibition of the weakened one. The aim of the technique is to cause a response antagonistic to anxiety to occur (in this case the pleasurable feel of materials from velvet to rabbit fur in the presence of the anxiety-evoking stimulus of a cat).

An analogy is presented by the method of Jersild and Holmes (1935) for treating a child's fear of dogs through a puppy. The puppy is sufficiently unlike a grown dog to elicit fear to only a small degree, while its antics create pleasurable responses. As it grows, these pleasurable responses spread to all dogs.

Nicolas Malleson, of London, in discussing Drs. Freeman and Kendrick's paper, recommends an alternative technique. "Here the subject exposes himself to the phobic stimulus, but makes every effort to produce a maximum anxiety response within himself. He steadily concentrates his full attention on his anxiety sensations, and their physical concomitants, without making any effort to terminate them by "escape." The intention, by analogy, is for the patient to build up a reactive inhibition to the anxiety response (which is subjectively experienced, after a few minutes' unpleasantness, as a tendency for the mind to wander, or as a sense of irksomeness, even boredom). When finally he is unable to sustain concentration on his anxiety any longer, and his sensations or thoughts change, still in the presence of the phobic stimulus, what may be likened to a habitual inhibition of anxiety takes place. Repeated practice of such exercises can certainly relieve some phobics of their disability."

Leo Wollman, M.D.
Brooklyn, N. Y.

THE CURRENT DILEMMA IN PSYCHOTHERAPY. Rudolf Dreikurs, M.D., J. Existent. Psychiat., Vol. I, No. 2, pp. 187-206, Summer 1960.

In recent years, there has been an increasing interest in the subject of existentialism, and May 1960 saw the publication of the first *Journal of Existential Psychiatry*. More publications on the subject are appearing; in addition, the American Ontoanalytic Association has been organized. In the foreword to the first issue of their journal, it is stated: "Man is more than mere mechanism or statistical abstraction. Toward this conclusion evidence and opinion have been mounting. Resolving old discrepancies has only made new ones visible. Problems, not solutions, have become apparent in the search for a knowledge of man, of how he functions, and where he is going. Obviously, many observers of man-in-action have felt an unrest with theoretical frameworks that confine, rather than define. Too consistently overlooked has been the fact that the human organism is relatively open to new experience. . . . Man is not merely the prisoner of mental mechanisms, diagnostic categories, primitive urges, or repetitions. He is capable of the unexpected as well as the expected. It is this order of thinking we must employ in attempting to understand, much less treat, the individual patient."

In the second issue, which publishes seven articles, Dr. Dreikurs discusses "The Current Dilemma in Psychotherapy" and concludes that "scientific tools for the validation of personality do not exist. Yet, each practitioner in the field of psychology and psychiatry must operate on the basis of one concept or another. Current emphasis on eclecticism ignores the necessity of basic assumptions as schools of thought become discredited. The democratic evolution brought about a changing structure of society, which in turn led to revolutionary changes in the concepts of man. We are in the midst of the third psychiatric revolution, with new concepts opposing those of the past. Yet, the wide range of concepts of man, developed in the last few centuries, still co-exist and oppose each other. As new syntheses are found for previous conflicts of ideas and concepts, new contradictions emerge. The changes of concepts accompanying fundamental changes in our society are not limited to psychology; the application of basic scientific principles to the field of psychology is as yet unpopular and scorned."

James L. McCartney, M.D.
Garden City, N. Y.

PIGMENTARY RETINOPATHY IN PATIENTS RECEIVING HIGH DOSES OF A NEW PHENOTHIAZINE. Robert D. Weekley, M.D., Albert M. Potts, M.D., Jose Reboton, M.D., and Rupert H. May, M.D., A.M.A. Arch. Ophth., 64:95-106, July 1960.

Another new drug which produces an ophthalmoscopic picture somewhat resembling retinitis pigmentosa is reported. This complication seemed to be caused by: 1) high local concentration in the uvea, following high dosages; 2) a specific enzyme inhibition possibly associated with the piperidine ring in the side-chain of this and related phenothiazines, but modified by the substituent in Position 2. The ophthalmological picture seen in four cases resembled the reactions seen after NP-207. Therapeutic attempts did not alter the course of this retinopathy due to thioridazine.

T. F. Schlaegel, Jr., MD.
Indianapolis, Indiana

PERONEAL PARALYSIS A HAZARD OF WEIGHT REDUCTION. B. E. Sprofkin, M.D., A.M.A. Arch. of Int. Med., 102:82-87, 1958.

Weight loss and sitting for long periods of time watching TV with the legs crossed at the knees are the most important factors in producing "leg-crossing palsy," or compression of the common peroneal nerve.

CAROTID ARTERY OCCLUSION IN CHILDHOOD. H. Stevens, M.D., Pediatrics, 23/4:699-709, 1959.

The internal carotid artery may be the site of arterial occlusion in childhood. The diagnosis should be suspected in the presence of a "stuttering" pattern of recurrent focal neurological signs which may occur months before the actual onset of the hemiplegia occurs. Investigations for underlying hematological, metabolic or infectious disease and for congenital abnormalities should be carried out.

HEMORRHAGIC ENCEPHALOPATHY INDUCED BY HYPERNATREMIA. C. N. Luttrell, M.D., and L. Fineberg, M.D., A.M.A. Arch. Neurol. Psychiat., 81:4: 424-432, 1959.

In three infants, with hypernatremia due to diarrhea and vomiting, the following neurological signs were observed: alterations of consciousness, muscle twitches, tremulousness and convulsions. At autopsy, wide-spread intraventricular, intracerebral and subarachnoid hemorrhages were observed.

FATE OF RED BLOOD CELLS INJECTED INTO CEREBROSPINAL FLUID PATHWAYS. J. E. Adams, M.D., and S. Prawirohardgo, M.D., Neurology, 9:8:561-564, 1959.

Using dogs as the experimental animal, tagged red cells were injected into the cisterna magna. It was found that only 25% of the cells were absorbed intact. The rest of them became enmeshed in the arachnoid. The authors felt that a similar situation occurred in subarachnoid hemorrhage in the human, where hydrocephalus is produced by obstruction and failure of the absorptive mechanism.

TRIFLUOPERAZINE (STELAZINE) IN PSYCHONEUROSES. A. R. May, et al., J. Ment. Sci., 105:1059, 1959.

Twenty-nine psychoneurotic patients, treated in an out-patient setting, were studied by means of a double blind cross-over technique. Patients were rated by doctors, patients, relatives and the Wittenborne Scale. Only those who showed improvement by all these standards were considered to be improved. The results showed 18 in this category. The drug was used in a dosage schedule of 2 mg. t.i.d. for four weeks and seemed to be of particular value in those with phobic and obsessional symptoms whereas depressive symptoms did not respond.

SPONTANEOUS AND HABITUAL ABORTION, AN INTERDISCIPLINARY STUDY. R. J. Weil, M.D., and C. Tupper, M.D., Canad. Psychiat. Ass. J., 4/1:1-7, 1959.

In a study of the aborting woman, psychiatric study revealed that in 44% there was emotional immaturity with inadequate reserves to handle the emotional stress of pregnancy. An additional 44% revealed obsessive-compulsive characteristics with a poor tolerance for frustration. In 17 habitual aborters, studied over a long period of time, falls in urinary chorionic gonadotropin, estrogens and pregnanediol and a greater than normal lability of 17—ketosteroid excretion were correlated with acute emotional situations. When psychotherapy was added to the treatment program, 15% of the 17 habitual aborters became capable of carrying through a normal pregnancy to term.

TOXIC PSYCHOSIS FOLLOWING ATROPINE EYE-DROPS. J. P. Baker, M.D., and J. D. Farley, M.D., Brit. Med. J., 5109 (1390-1392), 1958.

An acute toxic psychosis with tachycardia was noted in a patient who received 1% atropine eye drops for about three weeks following an operation for retinal detachment. When the eye drops were discontinued, she promptly reverted to normal behavior. She was then given atropine subcutaneously to test its effects; this resulted in a return of her aggressive and hallucinatory behavior.

ETIOLOGIC FACTORS IN MENTAL DEFICIENCY. ERRORS OF METABOLISM. S. W. Wright, M.D., et al., A.M.A. Dis. of Child., 95: 5:541-562, 1958.

Various metabolic errors are considered: phenylketonuria, hepatolenticular degeneration, and H-Syndrome. The latter is characterized by amino aciduria, cerebellar ataxia and a congenital pellagra-like skin disease.

Derangements in carbohydrate metabolism are seen in galactosemia, and gargoylism. Errors in lipid metabolism include Tay-Sachs (Amaurotic Family Idiocy), Niemann-Pick's Disease, and Gaucher's Disease.

TIC DOULOUREUX: TREATMENT WITH DIPHENYLHYDANTOIN. J. F. Dorsey, M.D., et al., Clin. Med., 6:8:1395-1398, 1959.

Diphenylhydantoin, an anti-epileptic drug, has shown some promise in the treatment of Tic Douloureux. It relieved pain in approximately 50% of the patients treated. Two patients were sufficiently relieved to obviate surgery; five were completely free of pain.

TRANQUILIZERS IN THE OFFICE PRACTICE OF MEDICINE. H. S. Kaplan, M.D., Ph.D., N. Y. State J. of Med., August 1, 1959.

All current drugs are listed with their significant medical uses in medicine and surgery. The role of anxiety in purely emotional as well as psychosomatic disorders is considered. The limitations inherent in psychotherapy, at the hands of generalists as well as psychiatrists, point up the need for pharmacologic agents. The use of tranquilizers in the treatment of mental disorders generally allows for a more immediate alleviation of anxiety. Tranquilizers usually serve to facilitate psychotherapy. They differ from barbiturates because in effective doses, they decrease anxiety without clouding the sensorium hypnotically. In many emotional disorders, there is a disturbance in the septal nuclei, Papez circuit and the reticular activating system. Investigation has suggested that the tranquilizers modify these circuits both chemically and physiologically. Tranquilizers, although they are a remarkable adjuvant, offer no substitute for the compassion and understanding of the physician, be he psychiatrist or generalist. They also fail to teach the patient to modify his neurotic actions.

The indications for psychiatric referral are reviewed as well as the indications for treatment by the generalist. The use of superficial psychotherapy concomitant with drug therapy is presented as a technique readily available to the non-psychiatrist.

Obsessive and phobic reactions and depressions are not affected by tranquilizer therapy.

Phenothiazines should be used with care and preferably should not be used in the management of neurosis. Jaundice and agranulocytosis are two major side effects of the phenothiazines which demand caution in their use. Extrapyramidal symptoms, photosensitivity, convulsions and skin reactions may also occur as side reactions.

SCHIZOPHRENIA AS A WORLD-WIDE PROBLEM. J. L. McCartney, M.D., Dis. Nerv. System, 19:12:561-564, 1958.

First admissions for schizophrenia showed an incidence of 29%-37% in the U.S.A., 35% in China, 40% in Ceylon, 39%-67% in India, and 50%-70% in Japan. In the U.S.A., the incidence of schizophrenia was twice as frequent in negroes compared to native-born whites; the offspring of foreign born showed a much higher rate than those who were born to parents who were native-born. Schizophrenia was twice as frequent in those who lived in urban areas as compared to rural areas.

The author feels that the rapid changes in the social system and the destruction of the father-figure have produced considerable insecurity and links this to the resulting schizophrenia.

PROMISING RESULTS IN CRYPTOCOCCAL MENINGITIS. H. Rubin, M.D., and M. L. Furculow, M.D., Neurology, 8:8:590-595, 1958.

In 10 patients with chronic meningitis, the organism was isolated in the cerebrospinal fluid. Treatment with amphotericin B, intravenously, in dosage of 1 mg. per kg. was given daily or every other day for a total dose of 1.4 to 3.7 g. Of the 10 patients treated, two died (both had been moribund when treatment was started). Seven of the eight patients who received a full course of therapy eventually showed sterile spinal fluid. After a follow up of 14 months, two of the patients relapsed.

THE TIRED MOTHER SYNDROME. L. L. Lovshin, M.D., Postgrad. Med., 26:1:48-54, 1959.

In a study of 48 tired mothers, significant organic disease was not found. The author feels they were just trying to do too much and were trying to do it to perfection. He also feels that it is unwise to call every functional syndrome a psychoneurosis. Medication should be used for symptomatic relief, where indicated, but no medication can replace the value of the physician's reassurance when it follows a careful and thorough examination. The patient must learn to live within her limits, and the doctor must help her to see her limitations.

INTRACRANIAL MENINGIOMAS: A ROENTGEN STUDY OF 126 CASES. H. G. Jacobson, M.D., et al., Radiology, 72:3:356-367, 1959.

The most specific findings on ordinary film studies included: localized hyperostosis, localized increase in vascularity and calcification. Other frequent findings included: pineal shift, atrophy of the dorsum sellae and localized bone resorption.

THE CONTROL OF HUMAN BEHAVIOR. Mortimer Ostow, M.D., Int. J. of Psychoan., 40:1-14, 1959.

Is is the purpose of this study to study some of the methods through which human beings influence each other. It is pointed out that since goals are determined by instinctual needs, they are not susceptible to the influence of reason and logic, unless there is a readiness for acceptance.

Attention must be directed to the instincts. Either the threat to prevent gratification or the promise to facilitate it, or both, may be used.

The readiness to obey authority, parental drives and attitudes, imitation, identification, and the use of projection are all of value.

These methods are all ordinarily opposed by the intact ego—hence impairment of ego function will facilitate the success of these techniques. Pain, isolation and starvation, all used in modern brain washing, induce regression and with it an impairment of ego function. Regression can also be induced by threats of deprivation, inducing guilt and shame, creating a sense of awe, and induction into a group.

In overcoming resistance, one of the methods used is substitute gratification. A device to overcome resentment to authority is to create sympathy by showing that the authority is vulnerable—but this must be done carefully for vulnerability may be seen as a limitation of the leader's power.

W.D.

BOOKS RECEIVED FOR REVIEW

The following books have been received and will be reviewed in subsequent issues:

Culture and Mental Health, Marvin K. Opler, Editor. The Macmillan Company, N. Y., 1959. Pgs. 523. $8.75.

The First Five Minutes (A Sample of Microscopic Interview Analysis), by Robert E. Pittenger, M.D., Charles F. Hockett, Ph.D., and John J. Danehy, M.D. Paul Martineau, Publisher, Ithaca, N. Y., 1960. Pgs. 264. $6.50.

Projective Techniques With Children. Edited by Albert I. Rabin and Mary R. Haworth. Grune & Stratton, Sept. 1960. Pgs. 392. $11.75.

Anorexia Nervosa, by Eugene L. Bliss, M.D., and C. H. Hardin Branch, M.D. Paul B. Hoeber, Medical Division of Harper & Bros., N. Y. Pgs. 210. $5.50.

Tranquilizing Drugs, Harold E. Himwich, M.D., Editor. American Association for the Advancement of Science, Washington, D.C., March 1957. Pgs. 205. $5.00.

Psychopharmacology. Nathan S. Kline, M.D., Editor. Amer. Assoc. for Adv. of Science, Washington, D.C., 1956. Pgs. 175. $3.50.

Rehabilitation of the Mentally Ill, M. Greenblatt & B. Simon, Editors. Amer. Assoc. for Adv. of Science, Washington, D.C., Dec. 1959. Pgs. 260. $5.00.

Alcoholism, Harold E. Himwich, M.D., Editor. Amer. Assoc. for Adv. of Science, Washington, D.C., 1957. Pgs. 220. $5.75.

Epidemiology of Mental Disorder, Benjamin Pasamanick, M.D., Editor. Amer. Assoc. for Adv. of Science, Washington, D.C., Dec. 1959. Pgs. 336. $6.50.

The Riggs Story by Lawrence S. Kubie, M.D., Paul B. Hoeber, N. Y. Pgs. 182. $6.00.

Sight—A Handbook for Laymen by Roy O. Scholz, M.D. Doubleday & Co., N. Y., 1960. Pgs. 166. $3.50.

Emotional Forces in the Family. Edited by Samuel Liebman, M.D., J. B. Lippincott Co., 1959. Pgs. 157. $5.00.

A History of Neurology, by Walther Riese, M.D., MD Publications, N. Y. C. Pgs. 221. $4.00.

Meaning and Methods of Diagnosis in Clinical Psychiatry, by Thomas A. Loftus, M.D. Lea & Febiger, Phila., 1960. Pgs. 169. $5.00.

Hypnosis in Skin and Allergic Diseases, by Michael J. Scott, M.D. Chas. C. Thomas, Springfield, Ill., 1960. Pgs. 161. $6.50.

The Question of Fertility, by George Valensin, M.D. Doubleday, N. Y., 1960. Pgs. 296. $4.50.

Clinical Evaluation of New Drugs, S. O. Waife, M.D., and A. P. Shapiro, M.D. Paul B. Hoeber, Inc., N. Y., 1959. Pgs. 223. $7.50.

Encyclopedia of Medical Syndromes, R. H. Durham, M.D. Paul B. Hoeber, Inc., N. Y., April 1960. Pgs. 628. $13.50.

The Neurologic Examination, by Russel N. DeJong, M.D. Paul B. Hoeber, Inc., N. Y. Pgs. 1078. $20.00.

Erotic Symbolism, by Edward Podolsky, M.D., and Carlson Wade, Epic Publishing Co., N. Y., 1960. Pgs. 127. $7.00.

Transvestism Today, by Edward Podolsky, M.D., and Carlson Wade, Epic Publishing Co., N. Y., 1960. Pgs. 128. $7.00.

Rudolph Matas, by Isidore Cohn, M.D. Doubleday & Co., N. Y., 1960. Pgs. 431. $5.95.

Book Reviews

MENTAL RETARDATION. Proceedings of the First International Medical Conference at Portland, Maine. Peter W. Bowman, M.D., and Hans V. Mautner, M.D. (Editors). New York: Grune & Stratton, Inc., 1960. 530 pages. $12.50.

This rather massive volume is more of a textbook than a treatise for easy reading. Nevertheless, as stated in the Preface: "The time has come that medicine must assume its role of responsible and effective leadership based on the fact that the syndrome of mental retardation is primarily and predominantly a medical problem. It concerns the general practitioner, the obstetrician, the pediatrician, the neurologist and the psychiatrist long before it becomes a problem to the teacher, the psychologist and the social worker. These ancillary professions, as well as others closely associated with medicine like occupational and physical therapy, speech and music therapy, have learned to make constructive and impressive contributions primarily in the area of therapy and as part of our research teams. They expect and are entitled to dynamic and enlightened leadership."

This volume is a report of a conference held in 1959, divided into five sessions, during which thirty-eight papers were presented. There were eighty participants.

The first three sessions dealt primarily with the anatomy, physiology, and diagnosis of problems of mental deficiency, while the fourth session had to do more with therapy. The fifth session discussed childhood schizophrenia and childhood psychoses. The report of each session ends with a discussion.

The book is well printed and extensively illustrated. Numerous references are given throughout the volume, and the entire book is well indexed. It is a book which can be strongly recommended as a reference for all those working in the field of mental retardation and should be in every medical library.

James L. McCartney, M.D.
Garden City, N. Y.

OUR OBSTETRIC HERITAGE. The Story of Safe Childbirth. Herbert Thoms, M.D. The Shoestring Press, Inc., Hamden, Conn., 1960. 164 pp. $4.75.

The author, Emeritus Professor of Obstetrics and Gynecology at the Yale University School of Medicine, has long been known for his interest in the history of medicine. In this, his latest book, he presents a concise, extremely readable account of the development of the art and science of obstetrics. This is a fascinating story which might well be read and enjoyed for its drama alone. Since an understanding of the past is essential for an adequate comprehension of the present, this book is invaluable to anyone who delivers babies and who is interested in the evolution of obstetrics.

F. W. Goodrich, Jr., M.D.
New London, Conn.

THE OUT-PATIENT TREATMENT OF SCHIZOPHRENIA: A SYMPOSIUM. Sam C. Scher and Howard R. Davis ((Editors). New York: Grune and Stratton, 1960. 246 pages. $5.75.

The title of this excellent review of current concepts of schizophrenia is extremely modest, since it covers not only the out-patient treatment, but every possible aspect of this illness. Because it represents the thinking of many authorities, with their expected differences of opinion, its coverage is not only comprehensive but most challenging.

Dr. Paul Hoch, as the opening speaker, noted the contributions of Kraepelin and Bleuler and the different diagnostic approaches of the various schools of psychiatry, emphasizing that best results were obtained in ambulatory patients by a combination of drug therapy and psychotherapy. In the discussion, Dr. Rado's comments were more of a "criticism of the present day state of psychiatry than of Dr. Hoch's paper." He suggested the need for two basic sciences, one physiological and the other psychodynamic. As for theories, he felt that they should be used as long as they produced results, but that one "shouldn't get married to them."

Dr. Silvano Arieti rejected the hypotheses that the illness was hereditary, metabolic, biochemical or neuropathological. He was convinced (and remained that way throughout the conference) that schizophrenia was a purely psychogenic and functional condition.

Dr. Milton Wexler proposed that "ego weakness" was the central link. He suggested that therapy was essentially a "feeding" process and not an explanatory one.

Dr. Leo Kanner noted that the "smug certainty about schizophrenia has been sloughed off . . . although there was still much groping and more or less emotionally tinted clinging to cherished opinions."

Bluma Swerdloff, in discussing treatment, felt that the key was to reduce anxiety, fear and anger. The schizophrenic needed direction rather than a probing of internal psychological conflicts.

Dr. George E. Williams spoke about the precipitation of crisis by intense fear or panic. He suggested that the therapist should offer "interest, a kindly curiosity and a real desire to help." Dr. Rado pointed up that "excavatory work" might usher in disintegration. Most important was the need to help the patient adapt to his genetic damage. He felt that in time he "might become accessible to biochemical replacement therapy." He emphasized that a psychotherapist who sits like a "Buddha" can do no effective work.

Dr. Rado then presented a theory and therapy based on "schizotypal organization." Two fundamental defects were noted, both the result of genetic influences: 1) a diminished capacity for pleasure, and 2) a distorted awareness of one's own body. These defects are compensated by: 1) extreme overdependence, 2) "scarcity of pleasure," and 3) a vast increase in the patient's craving for magic. In therapy, most important was the removal of the symptoms of "emergency dyscontrol"; only then can pleasure capacity be increased. The patient must then be taught to live within his genetic limitations.

Dr. Arieti presented the aspects of psychoanalytically oriented therapy. He considered the problem of "relatedness"; it was not only important to consider the feelings of the patient for the therapist, but the feelings of the therapist for he patient.

The "Drug Treatment of Schizophrenic Outpatients" was considered by Drs. Lowinger and Gottlieb. Studies were described where patients were seen, once or twice a month in 10-15 minute sessions. They felt that it was proved to be possible to combine the treatment of ambulatory schizophrenics with the evaluation of new drugs.

"Family-focused Therapy of Schizophrenics" was then discussed by Dr. Ackerman. The basis for this treatment was the therapeutic interview of the entire family, since he regards the illness as "the result of the failure of the biosocial functioning of the family entity." The quality of "deadness" in the schizophrenic family was noted, also the ritualized and mechanized relationships.

In considering "Research," Dr. Hoch spoke of the promising results of the pharmacologic approach. As for the evaluation of the many various therapies proposed for the illness, he pointed out the paucity of long range follow-up studies and the need for better definitions of the criteria of improvement. Shorter and more effective psychotherapy was needed.

This highly readable and most complete study of schizophrenia is most heartily recommended. Psychiatrists of various schools of persuasion will find reassurance as well as a challenge for their giving their thoughtful consideration to the complexity of the problem. Non-psychiatrists will add considerably to their understanding, comfort and ability to manage the many undiagnosed schizophrenics who masquerade under various somatic disguises, whose "medical" treatment has proven to be not only ineffectual for the patient but often frustrating and provocative for the doctor. Only through a basic knowledge of the illness can the physician maintain his own equanimity in his attempt to meet the unreasonable needs for "magic" of these patients.

W.D.

SOMATOSENSORY CHANGES AFTER PENETRATING BRAIN WOUNDS IN MAN. By Josephine Semmes, Sidney Weinstein, Lila Ghent, and Hans-Lukas Teuber. Cambridge: Harvard University Press, 1960. 91 pages. $4.00.

This monograph is one of a series of studies which have been underway for more than ten years. This investigation has been carried out at the New York University-Bellevue Medical Center and is a carefully worked out statistical study. The laboratory has mainly relied on a group of 350 veterans with combat injuries of the nervous system; of this number, 232 sustained penetrating brain wounds. The remaining 118 were considered a control group, since they suffered missile wounds of the peripheral nerves, but not of the brain. These cases have been followed for many years. Most of the men were approached several years after the wounding, and the testing continued at irregular intervals for ten years or more. The authors have applied quantitative methods in assessing sensory function.

This small volume is divided into seven chapters. There are eighteen tables, and nine figures. The whole is well indexed, and there is a long list of references. In their conclusions, the authors state that the left and right parietal lobes do not function equivalently. Sensation of the left hand is more diffusely represented in the contralateral hemisphere than that of the right hand; sensation of the left hand is frequently affected by lesions of the ipsilateral sensorimotor region. About half of their subjects experience episodes of post-traumatic epilepsy, but the proportion of subjects with epilepsy is approximately equal in the groups with right and left unilateral lesions. To sum up, they state: "If the differential role of the two hemispheres in sensation should turn out to be a general feature in adults, one might inquire as to the origin of this asymmetry. Perhaps lateralization of motor function is the first to appear in the child, followed by the differential development of sensory representation. The concentration of language

functions in one hemisphere may come last of all. In any event, the gradual emergence of the hemispheric differences which are suggested by our work might be a rewarding topic for future investigation."

James L. McCartney, M.D.
Garden City, N. Y.

PSYCHOANALYSIS AND PSYCHOTHERAPY—36 SYSTEMS. Robert A. Harper, Prentice-Hall, Inc., 1959. 182 pp. $1.95.

The non-psychiatrist, who is often confused by the multiplicity of "systems" in psychiatry and by the doctrinal strife among his psychiatric colleagues, has long needed an authoritative guide. It is important that such a guide be concise, clear and definitive. Despite the fact that proponents of any particular school may find this volume to be oversimplified, or that their point of view is not adequately stated, it seems to this reviewer that this is a book which meets the basic requirements. The author reviews the basic tenets of 36 systems and concludes with a critique which is very helpful. This comprehensive survey is recommended to all non-psychiatrists who are interested in resolving their confusion concerning the various psychiatric schools.

F. W. Goodrich, Jr., M.D.
New London, Conn.

GROUP PROCESSES. Transactions of the Fifth Conference, October 12, 13, 14, and 15, 1958, Princeton, N. J.: Bertram Schaffner, M.D., Editor. New York: Josiah Macy, Jr. Foundation, 1960. 196 pages. $4.50.

During the past fifteen years, the Josiah Macy, Jr. Foundation has conducted about twenty conference groups, and each group has been meeting for at least two days annually over a period of five years. Each group is limited to twenty-five participants, and the object is to promote communication, exchange of ideas, and the stimulation of creativity among the participants. The results of these conferences, in stenographic form, are being published, and this present volume is such a report and discusses "Experimental Aspects of Pediatrics," "The Analysis of Behavior in Terms of Control Systems," and, "The Cult as a Condensed Social Process."

The last chapter, under the guidance of Margaret Mead and Theodore Schwartz of the American Museum of Natural History, is the most interesting, and is followed by a list of thirty-five references. The whole book is well indexed.

These conference reports are a source of information but are not conclusive in themselves, but, as stated on page 83, in the second chapter: "There is little doubt that many of the physiological information flow systems dealt with in this discussion still have a long road of analysis to go before reaching the point where they can be treated in neurophysiological terms. There is no reason, however, why this point should be inaccessible, if the suggested analytical procedure is pursued with the stringency and effectiveness that it allows."

James L. McCartney, M.D.
Garden City, N. Y.

ATLAS OF TUMORS OF THE NERVOUS SYSTEM. By H. M. Zimmerman, M.D., M. G. Netsky, M.D., and L. M. Davidoff, M.D. Philadelphia: Lea & Febiger, 1956. Pgs. 191 with 277 illustrations. $25.00.

This atlas, containing no less than 277 illustrations, 233 of which are in color, is a full-fledged course of study of neoplasms of the nervous system, inclusive of metastatic lesions and other space occupying lesions. The text material is succinct, with a minimum of debatable esoteric material and correlates well with the excellent illustrations of the gross and microscopic pathology.

This book is of value not only to the neurosurgeon and neuropathologist, but to the clinician. Whether one's primary interest is in the field of neurology or in general medicine, the reader will be exposed to a most rewarding clinical experience.

W.D.

LOVE IN ACTION. The Sociology of Sex. Dr. Fernando Henriques, M.A. New York: E. P. Dutton & Co., Inc., 1960. 432 pages. $5.95.

The author of this book holds M.A. and Ph.D. degrees from Oxford University and is a lecturer on social anthropology at the University of Leeds in England. This is a very thorough study of sexual customs all over the world and throughout history. It is fascinating reading and obviously is a result of much research. As pointed out in his postscript, he has "attempted to survey some aspects of the sexual activity of man in society. Man is endowed with certain biological equipment which provides the basis for his sexual behavior. Obviously, without continued generation, society cannot persist. The problem which confronts man is to secure the ordered sequence of events by which children are born in a socially approved way, and to satisfy his sexual needs. How the problem is solved depends upon the whole configuration of cultural factors which occur in a particular society at a particular time. In other words there is not one solution but rather a great number. The culture may permit the dominance of the sexually uninhibited woman as in the Marquesas Islands,

or it may demand the austere sexual standards of the aboriginal Veddas of Ceylon. Neither solution is more correct than the other. They are merely different ways of solving the same problem.

"For the individual in our own type of society a consideration of alternative methods of solution can be salutary. Not that we should adopt customs and practices evolved in another cultural context, but it may enable us to view our own institutions with a mind less full of righteousness. We have now reached the stage where more and more individuals are claiming the right to create their families in their own time and not nature's. Birth control has established sexual love in marriage on a different basis. Are we now prepared to extend the right of sexual love to the unmarried? Are adolescents to continue their explorations of sex in the clandestine and furtive manner characteristic of this phase of sexual life? We are now beginning to recognize the distinction between the reproductive principle in marriage and the enjoyment of sexual pleasure. Will society sanction the expression of adolescent sexuality? It is possible that a consideration of the sexual behavior of societies other than our own might help towards a solution of such problems."

There are twelve chapters, entitled: "Preparation for Sexual Life," "Pre-Marital Sexual Behavior," "Modesty," "Love and Love Magic," "Love-Making," "Courtship," "Regulation of Sexual Life," "Marriage Rites and Ceremonies," "Divorce," "Coitus and Tabu," "Beauty," and "Extra-Marital Sexual Intercourse." Each chapter is followed by an extensive list of references, and there are sixty-nine illustrations and plates.

In the first chapter, he fully discusses the subject of circumcision and the rituals that lead to the assumption of the adult role in society. In chapter 4, page 94, he states: "Attraction between the sexes is not always mutual. The desire of reciprocal passion, however, is universal. A constant motif in romantic literature throughout the world is that of the rejected lover. Wonderful as are the effusions promoted by unrequited love, the individual is often not content to remain in this state. He or she is driven to practical or near-practical means to achieve the object of his or her heart's desire." In chapter 6, page 176, he states: "The Americans, like all other peoples, suffer from ethnocentrism. One form it takes is the belief that their dating system is normal courting behavior. The attempt to put it into practice in Europe, during the war, led to absurd situations. On the one hand, English girls were outraged at what they regarded as premature attempts at seduction; on the other hand the young G.I. who found his girl friend ready for intercourse on the first date was disgusted." In chapter 10 he discusses at some length the frequency and restrictions placed on sexual intercourse and emphasizes that these practices are governed by factors other than strictly sexual. "In the case of our own type of society the pattern fulfills that of the expected passivity in woman." He points out that "there is a correlation between the sexual role which woman adopts and the amount of sexual satisfaction achieved by her. . . . The ideal is perhaps for the woman to exhibit a becoming reticence and at the same time to gain and administer full pleasure." He further points out in chapter 11: "Woman instead of being either a harlot or a saint is now a being of physical charm but possessing mental powers similar to man. This is partly due to the complete change in woman's status from the one century to the other. Equality of the sexes is incompatible with beauty out of reach on a pedestal. This is reflected not only in literature, but in the new mass media of the twentieth century. The ideal woman is in many ways different from her predecessors. Possibly the most significant difference is in the fields of social relationships and clothes, both of which provide a freedom of movement in direct contrast with the preceding century."

This book should be in the library of every physician, and especially the psychiatrist. It helps to clarify much that has been written on sexual relationship between the sexes and consequently helps to explain human behavior. The whole volume is well indexed, and there is also a list of all the "simple societies," which are discussed in the text.

James L. McCartney, M.D.
Garden City, N. Y.

Psychosomatics

INDEX 1960 — Volume I

To Those Receiving This Journal as a Complimentary Copy:

This will introduce you to PSYCHOSOMATICS, the official journal of the Academy of Psychosomatic Medicine. This is a brand new publication focusing on an area of rapidly growing significance: the role of psychiatry in the daily practice of medicine. As a journal written for the medical profession generally rather than the psychiatric specialty specifically, PSYCHOSOMATICS will bring you pertinent, readable papers by physicians in all areas of medicine, keyed to the theme of treatment of the "total patient." In addition, for the busy practitioner there are reviews of books and abstracts of articles drawn from the entire medical literature. On the next page you will find the titles of a few of the papers scheduled for publication in subsequent issues. If you do not presently receive PSYCHOSOMATICS regularly you will certainly want to send in one of the coupons shown below.

ACADEMY MEMBERSHIP

(Includes a subscription to *Psychosomatics*)

I am interested in becoming a member of the Academy of Psychosomatic Medicine.

NAME .....

ADDRESS .....

G.P. ☐ SPECIALIST ☐ .....
Indicate specialty

Mail to Dr. Bertram Moss, 55 E. Washington Street, Chicago 2, Illinois

PSYCHOSOMATICS ORDER FORM

Please enter my subscription to PSYCHOSOMATICS for one year to start with the ..... issue, for which I will pay $10.00.

Name ..... Address .....

☐ Check enclosed. ☐ Bill me.

Mail to PSYCHOSOMATICS, 277 Broadway, New York 7, N. Y.

TAPE RECORDING ORDER FORM

Send to: DR. WILFRED DORFMAN
1921 Newkirk Avenue - Brooklyn 26, N. Y.

1 Emotional Aspects of Allergy and Dermatology
Handling the Patient with Chronic Illness

2 Interview Techniques
Psychiatric Education for the Non-psychiatrist

3 Sterility and Frigidity
Emotional Problems in Surgery and the Surgical Specialties

4 Psychopharmacology I
Psychopharmacology II

5 Psychosomatic Medicine Round Table

6 Group Therapy
Chest Pain—Somatic and Psychic Factors

7 Are Drug Therapy and Psychotherapy Compatible?
The Doctor as a Therapeutic Agent

Through the efforts of Dr. Milton Cohen of Lewiston, Pa., we now have tape recordings available of some of the sessions held at the October 1960 meeting in Philadelphia. The tapes are listed above on the order form and may be purchased for $9.50 each. Please circle the numbers opposite the tapes you want and send the order form, together with remittance to Dr. Wilfred Dorfman, 1921 Newkirk Ave., Brooklyn 26, N. Y.